RELATIONSHIP OF ETHNICITY TO CONCEPTIONS OF MENTAL ILLNESS AND ATTITUDE TOWARD SEEKING PSYCHOLOGICAL HELP

BY

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In memory of my father and mother who were always very proud of me.

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The purpose of this study was to investigate the relationship of ethnicity to conceptions of mental illness and help-seeking attitudes among school teachers, and to examine the relationship of help-seeking attitude to conceptions of mental illness. It was hypothesized that conceptions of mental illness, and attitude toward seeking psychological help are related to ethnicity and not to other demographic variables. It was also hypothesized that there is a relationship between attitude to seek help and conceptions of mental illness.

Four instruments were presented to 513 school teachers employed by the Alachua County School Board in Florida. These were the Nunnally Conception of Mental Illness Questionnaire, the Fischer and Turner Pro-Con Attitude Scale, ten vignettes that investigated opinions on certain counseling issues, and a Demographic Information Questionnaire.

The sample consisted of 321 whites and 192 blacks. The responses they gave to the items were analyzed by hierarchial multiple regression analyses. The demographic variables

that were considered relevant in these analyses were race, sex, age, marital status, highest education obtained, religion, and income.

The results showed that blacks and whites had similar attitude toward seeking psychological help; therefore, help-seeking attitude was not related to ethnicity. There were, however, differences in conceptions of mental illness in seven of the ten components of the conception scale, with blacks' conceptions being more stereotypic and whites' closer to those of mental health professionals. Analysis of the responses on the vignettes also showed that blacks and whites responded differently, with blacks responding more liberally to mix-race, cross-cultural dyads in counseling. They, however, scored lower than whites on items that investigated the efficacy of psychological treatment for certain problems.

The results indicated the possibility of cultural differences in conceptions of mental illness. These results might have important implications in the underutilization of mental health facilities by blacks as well as in the strategies employed in psychological interventions.

CHAPTER 1

INTRODUCTION

The function of counseling is essentially to establish a temporary means oriented coalition with the client against the problem. Unless such a coalition can be established, the problem will continue to control the client and isolate the counselor (Pederson, 1977). The effectiveness of counseling is increased when the couneslors involved in these coalitions have an understanding of the dynamics at work. Differences in value perspectives of age, sex, lifestyle, socioeconomic status, all interact to affect the counseling process (Bellis, Redlich, & Hollingshead, 1955; Hollingshead & Redlich, 1958; Lorion, 1973).

In addition to the above investigations, research has focused on popular conceptions of mental illness (Nunnally, 1961; Rabkin, 1974), as well as attitudes toward mental illness and treatment (Crocetti & Lemkau, 1963; Edgerton, 1969; Fischer & Cohen, 1972). Investigations such as these are enabling mental health professionals to get a better understanding of the clients that they are trying to help. These investigations have also shown that public conceptions and attitude toward seeking psychological help vary according to the educational level, age, income, sex of individuals (Gurin, Veroff, & Feld, 1960; Nunnally, 1961).

A few researchers have investigated cultural conceptions of mental Illness (Karno & Edgerton, 1969; Sue, Wagner, Davis, Margullus, & Lew, 1976; Townsend, 1978), but very little is known about the ways in which blacks' conceptions of mental illness and attitudes toward seeking psychological help differ from those of their white counterparts here in the United States. However, the underutilization of mental health facilities by blacks has become a growing concern among mental health professionals, and the attitudes toward white mental health professionals and the use of mental health facilities have been widely researched (Davis & Swartz, 1972; Miller, 1980; Tucker, 1979).

The fact that little is known about blacks' conception of mental illness is surprising based on the fact that black people have become one of the most widely researched minority groups in counseling literature (Smith, 1977); but much of this research has not led to a better understanding of how to counsel them. Many mental health professionals have concluded that racial or ethnic factors may act as impediment to counseling (Atneave, 1972; Carkhuff & Pierce, 1967; Ruiz & Padilla, 1977; Sue, 1975; Vontress, 1971). These barriers to effective counseling often lead to alienation or inability to establish rapport with the culturally different (Sue & Kirk, 1975). Third World clients underutilize mental health services (Sue & Kirk, 1975; Yamamoto, James, & Palley, 1968) or prematurely terminate after an initial contact. Sue and Kirk (1975) stated that there seems to be unanimous agreement

among professionals that many Third World clients find the values of counseling to be inconsistent with their life experiences. Could underutilization of mental health facilities by blacks be related to their attitude toward seeking psychological help and conceptions of mental illness? Are these attitudes and conceptions different from those of their white counterparts?

Purpose of the Study

The purpose of this study was to determine black and white school teachers' attitudes toward seeking psychological help and conceptions of mental illness. Specifically, this study was designed to provide answers to the following questions.

1. What is the relationship between help-seeking attitude and ethnicity of school teachers?

2. What is the relationship between conceptions of mental illness and ethnicity of school teachers?

3. Is there a relationship between conceptions of mental illness and help-seeking attitudes among school teachers?

From the above research questions, the following hypotheses were formulated.

Hypothesis I

Help-seeking attitudes are related to ethnicity and not to other demographic variables.

Hypothesis II

Conceptions of mental illness are related to ethnicity and not to other demographic variables.

Hypothesis III

Attitudes toward seeking psychological help are related to conceptions of mental illness.

Rationale

The functions of teachers as socializing and educating agents in our society have earmarked them as target populations when knowledge is to be accumulated pertaining to aspects of life that will affect personal growth and development. Conceptions of mental illness and attitudes toward seeking psychological help are pertinent to such growth and development, and hence pertinent to teachers. Mental health professionals have long been aware of this and have concentrated their research efforts in this area (Rabkin & Suchoski, 1967; Yamamoto & Dizney, 1967).

Another aspect is the day-to-day judgments teachers are expected to make concerning mental health/illness of their students, and the comcomitant nonreferral or referral to guidance counselors and other mental health service providers. It is, therefore, of paramount importance to mental health professionals that teachers' views of mental illness and attitude toward seeking help parallel their own, and to correct whatever differences that exist through appropriate mental health education programs. One of the primary purposes of this study was to obtain base-line data on these issues.

Organization of the Study

The remainder of this study is organized into four chapters and appendices. A review of the literature related to conception of mental illness and demographic correlates of public attitude and information concerning mental illness is presented in Chapter 2. Chapter 3 contains a description of the methods and procedures employed. A summary of the results is presented in Chapter 4. Discussion and implications are presented in Chapter 5.

CHAPTER 2

A REVIEW OF THE RELATED LITERATURE

The review of the literature related to the investigation is divided into several broad areas: (a) some definitions of mental health and mental illness, (b) popular conceptions and attitudes concerning mental illness, (c) demographic correlates of conceptions and attitudes concerning mental illness, (d) changing ideas of mental illness and its treatment, (e) relationship of knowledge and attitude toward mental illness, (f) cross-cultural attitude toward and conceptions of mental illness, and (g) utilization of mental health facilities by blacks.

Mental Health/Illness--Some Definitions

A definition of mental health has been studiously avoided by all its proponents. Thorpe (1950) stated that the reason for this is that mental health may have different meanings or implications at different times but can be described in terms of negative or positive factors. From the negative point of view, mental health has reference to the absence of symptoms of maladjustment, be they mild or severe. Such symptoms range along a continuum from feelings of guilt or inferiority through psychosomatic disorders and the psychoneuroses, to the organic and functional psychoses. The mentally healthy individual is free from such maladjustments.

On the positive side, mental health means satisfactory adjustment and adaptation by the requirement of group life. Such adjustments can be described in terms of degree. A broad aspect of such adjustment is that of adjustment of individuals to themselves and the world at large with a maximum of effectiveness, satisfaction, cheerfulness, and socially considerate behavior, and the ability to face and accept the realities of life. An even higher degree, according to Thorpe, is the experiencing by the individual of the greatest success which his abilities make possible, with a maximum sense of well-being on his own part, and the highest possible benefit to society.

Dannenmaier (1978) stated more cautiously that mental health appears to be a state of affairs primarily within the individual, which permits an optimal exercise of his talents and a steady movement toward an optimal satisfaction of his needs. He further stated that in some cases, society decides that an individual's mental health is bad, without that individual's full agreement. The problem of mental health is therefore multidimensional. The major sources of problems being either within the person and/or between the person and the society in which he lives.

Gladstone (1978) posited adaptability as the goal and measure of mental health. Behavior that may have been defined as adaptable in America fifty years ago may not hold true today. He further stated that a time period creates different modes of adaptability, but in general, adaptability implies the ability to love, work, play in a balanced measure.

Gladstone sees mental illness as the converse of mental health. For him, the notion of mental illness involves restricted patterns of adaptation ending ultimately in the inability to adapt at all, or in death.

Gallagher (1980), unlike Gladstone, did not see mental health and mental illness as minor opposites of each other but believes this approach is used because it is manageable. He had posited that it is the cultural variation of what is normal that makes the opposite approach unmanageable. He believes that there is no psychologically meaningful and operationally useful description of what is commonly understood to constitute mental health. He claims that absence of mental disorder, correct perception of reality, adjustment to one's environment, and intrapsychic equilibrium are the themes he comes across most frequently in attempts to delineate mental illness.

Miles (1981) asserted that the question of who is mentally ill has proved an exasperatingly difficult question to answer and that there is no concensus of opinion on the subject in spite of the voluminous literature. A somewhat plausible suggestion to solve this definition problem was proposed by Crocetti, Spiro, and Siass (1971). This was the suggestion to adopt a multiple model of mental illness. They pointed out that it is ironic that at a time when virtually all data point to the need for multiple models to understand the varieties of mental illness, pleas are being advanced for regression to an oversimplified unitary model of social

deviancy. They contend that such oversimplification runs counter to the mounting data from such diverse sources as anthropology and existential epistemology, psychophysiology and behavioral psychology, sociology and neurochemistry, and psychoanalysis and phenomenology.

As Miles (1981) pointed out, the debate about the concept and nature of mental illness, conducted by medical and social scientists, is remote from the daily practice of professionals, and even more so from the everyday lives of laymen. He claimed that despite the lack of accepted definitions, lay people make frequent use of the term mental illness, or one of its many substitutes (such as "crazy," "mental," or "mad") and have their own ideas as to what these mean.

Popular Conceptions and Attitudes Concerning Mental Illness

Scott (1958), in his review of the research definitions of mental illness, concluded that underlying the diversities in definitions one can discern basic differences of viewpoint concerning how the phenomena should be conceptualized. Disagreements, he claims, can be abstracted by the following four points of contention: (a) does mental illness refer to a unitary concept or to an artificial grouping of basically different specific disorders, (b) is mental illness an acute or chronic state of the organism, (c) is maladjustment (or deviance from social norms) an essential concomitant of mental illness, (d) should mental illness be explicitly defined according to the values other than social conformity? He conjectured that the resolution of disagreements would

depend in part on the outcome of future empirical research but adds that "at least some of the divergence inheres in the theoretical formulation of the problem, and is more a matter of conceptual predilection of empirical fact" (Scott, 1958, p. 39).

Over the past forty years, mental health professionals have become increasingly interested in not only professional conception of mental illness, but those of the public as well. Definition of mental illness made by the lay public is crucial with regard to who is treated and comprehension of medical care programs requires an understanding of how such definitions are made. Persons recognized and treated may not be those most in need of treatment by psychiatric criteria because the physician trained in the treatment of the mentally ill applies different criteria to behavior than does the layman (Mechanic, 1962).

One of the earliest researches into the investigation of information concerning mental illness was by Ramsey and Seipp (1947). Interviews were conducted by the researchers and five graduate assistants. All questions were presented orally to 345 respondents. In this investigation, data were collected concerning opinions, attitudes, and information on various aspects of nervous and mental illnesses. The respondents consisted of a fairly representative group taken from the population of Trenton, New Jersey. The answers given by the respondents as to the cause of insanity were primarily stated in terms of naturalistic rather than mystical or

supernatural concepts. However, some of the naturalistic explanations were contrary to known facts or at least questionable in light of present-day knowledge. Explanations of the causes of mental illness usually were based upon psychogenic concepts. The researchers reported that only very few individuals gave evidence of being able to differentiate between the major and minor forms of mental illness. Symptomatologies of mental diseases and environmental forces surrounding the individual frequently were considered to be causes of insanity.

One series of the questions sampled attitudes and opinions concerning mental health. The first of the questions, as reported by the researcher, pertained to the association of sin and insanity. Seventy-four percent of the people interviewed did not believe that insanity came as God's punishment for some sin or wrongdoing, but 20% of the respondents still adhered to this belief. Regarding the role that inheritance plays in insanity, it was found that 20% of the respondents felt that insanity was completely due to heredity, whereas 32% thought heredity bore no relationship to insanity at all.

Of the questions concerning attitudes toward the prognosis of mental illness and the type of treatment people would recommend, 91% of the respondents felt that something could be done for individuals who were exhibiting "very strange and odd behavior." The researchers reported that most of the respondents recommended some sort of professional

care, but about 25% did suggest some type of home care and treatment.

Another of the early researches into the investigation of conception of mental illness by the public was by Star (1955), who asked a sample of 3,500 respondents about six case abstracts of mentally ill persons (a paranoid schizophrenic, an alcoholic, a depressed neurotic, a simple schizophrenic). Of the sample, 17% said that none of these imaginary persons was mentally ill, and another 28% limited their concept of mental illness to the paranoid schizophrenic--the only description where violence was a predominant feature of the behavior.

Cummings and Cummings (1957) developed a mental health education program within the Blackfoot Community (Prairres Province in Canada). According to the researchers, the citizens there had achieved little awareness of their own attitude toward mental health and mental illness. The researchers ascertained attitudes and beliefs of the local population prior to the program and at the conclusion of their educational efforts.

The Cummings' not only experienced a strong resistance on the community's part to change their attitudes, but there was also a pervasive "normalizing" theme. This consisted of a tendency of the respondents to dismiss described psychological symptoms with comments such as "it's just a quirk" or "it takes all sorts to make a world." They reported that some respondents denied the seriousness of even the

bizarre behavior of the paranoid schizophrenic. This denial, they claim, is one of the crucial differences between lay and professional judgments of psychological symptoms.

By the 1960's, the exploration of public information and attitude began to mushroom as a possible consequence of the previous researches (Cummings & Cummings, 1957; Joint Commission on Mental Health, 1961; Star, 1955). The Joint Commission on Mental Health (1961) reported that there was a major lack of recognition of mental illness as illness, and a predominant tendency toward rejection of both the mental patients and those who treat them.

The Lemkau and Crocetti (1962) study did not find evidence to support the concept that there was a tendency on the part of the public to "deny" mental illness, but found some evidence of what the Joint Commission described as "pervasive defeatism" concerning the mentally ill.

Nunnally (1961) reported a wide range of studies which not only assessed public and professional information on mental illness but also researched public attitude toward the mentally ill, putlic attitude toward experts and treatment, as well as studies on information transmission and attitude change.

The instrument developed by Nunnally to measure conception of mental illness has been used by several other researchers. From the data that Nunnally collected, he reported that there is a dislike and fear of the mentally ill and that there is an overall tendency to degrade

mental health concepts, that the stigma is pervasive and not easily changed by schooling and other cultural influences.

Nunnally claimed that whereas the information held by the public is not really "bad" in the sense that the public is grossly misinformed; the attitudes held by the public are as bad as is generally expected. He also claimed that one of the most important findings was that there was a strong "negative halo" associated with the mentally ill and that such unselectively negative attitude may in part be due to a failure to observe and learn mental health phenomenon in daily life.

When Nunnally researched the public's attitude toward mental health professionals, using semantic differential scales, he found that in the case of the comparison between doctor and psychiatrist, for example, the psychiatrist was rated less favorably on every scale, and on 14 of the 19 scales used, this difference was significant beyond the .01 level by t-test. When psychologist was compared to doctor, the average absolute difference (showing the doctor as more generally favorable) was significant beyond the .01 level 16 out of 19 times. In general, nurse was rated more favorably than psychiatrist. On 14 of the 19 scales, the differences were significant at the .01 level of confidence by t-test.

The study investigating attitude toward treatment methods and institutions showed that hospital was rated as much more valuable, safe, predictable, and understandable than mental hospital. The results for treatment techniques

were similar with physical treatment looked at more favorably than mental treatment. The mean differences between the attitudes toward the two types of institutions were much more pronounced than were the mean differences between the attitudes toward mental and physical health professions.

Studies such as those by Crumpton and Wine (1965) investigated conceptions of normality and mental illness held by normal and schizophrenic adults. The researcher pointed out that the results made it clear that there are differences between normals and schizophrenics in their conceptions of normality and mental illness. They stated, though, that they could not determine with complete certainty what the differences were but saw them as intriguing leads. According to the results, the normals said the mental patient was sick; the schizophrenics said the mental patient was not sick, he was immoral. The normal thought the patient was dangerous, but the schizophrenic considered him safe. The normal said a man can be neurotic and still be normal; the schizophrenic did not know what it took to be normal.

Another study (Crumpton, Weinstein, Acker, & Annis, 1967) investigated how patients and normals see the mental patient. They reported that the image of mental patient, as seen by both patients and normals was "unflattering." However, they found that patients were more charitable toward the concept of "mental patient" than were the normals. Again, the notion that normals view mental illness in terms

of sickness and danger, while patients' views were more in moral terms, were reflected in this study.

As exemplified by the last two studies cited (Crumpton et al., 1967; Crumpton & Wine, 1965), research on public information and attitude in the late sixties began to be directed at specific populations, and with this new approach, teachers also became a focus of interest to researchers (Rabkin & Suchoski, 1967; Yamamoto & Dizney, 1967).

The role of education in improving information and attitude was recognized by the Joint Commission on Mental Health (1961). Rabkin and Suchoski asserted that if there is to be any success in bringing about any basic alteration in information of, and attitude toward mental illness, then the schools must play a prominent part in the campaign. They further asserted that the child not only learns from the direct tuition of the teacher but incorporates as well his attitudes and conceptualizations about the world. This is as true for the grade child as it is for the college student. They claim, therefore, that if teachers are to be entrusted with the responsibility for disseminating this information, it is important that it is known what information and attitude they possess.

In this investigation, 107 teachers taking summer courses at the University of Washington served as subjects. Information about mental illness was measured by the questionnaire developed by Nunnally (1961). This was a forty item questionnaire consisting of a series of statements concerning

mental health problems. All subjects were asked to indicate the extent of their agreement or disagreement with such statements as

1. Will power alone will not cure mental disorders.

2. Psychiatrists try to show the mental patient where his ideas are incorrect.

3. Mental health is largely a matter of trying hard to control emotions.

The 40 items were factor analyzed into ten components of four questions each, representing the following concept clusters.

1. Look and act different--the mentally ill are obviously aberrant in manner and appearance.

2. Will power--people who are mentally ill are not utilizing will power and trying to get better.

3. Sex distinction--women are more likely to develop mental disorders than men.

4. Avoidance of morbid thoughts--positive thinking is the key to mental health.

5. Guidance and support--mental health is maintained by relying on strong persons in the environment.

6. Hopelessness--little can be done to cure mental disorders.

7. Immediate external environment versus personality dynamics--immediate environment pressure versus personal history is seen as the prime etiological agent in mental disorder.

8. Nonseriousness--emotional difficulties are really trivial matters.

9. Age function--older people are more prone to emotional disorders.

10. Organic causes--a mental disorder is caused by organic factors and nervous system disease.

The second set of data consisted of a measure of attitudes toward, and connotative meaning of, mental health concepts. The Semantic Differential measuring instrument by Osgoode, Suci, and Tannenbaum (1957) was used.

The researchers found that, on the whole, teachers are reasonably well informed concerning mental health problems. Their responses were compared to data from an Illinois study representing the responses of a sample group of the general public and a sample of psychiatric experts. Except for components 9 and 10, their responses fell to the more "correct" side of the public's responses. The differences between teachers and experts were relatively small.

However, the researchers reported that when it came to the more affective components of their response (the attitudinal aspects), teachers unfortunately presented a picture similar to that of the general public. Mental patients were "viewed with distrust, and generally devalued, were seen as strange and incomprehensible, as well as unsafe" (Rabkin & Suchoski, 1967, p. 40).

The overall findings, however, when the literature was reviewed by Crocetti et al. (1971), was that (a) the "man

in the street" had bought the mental health story and believed to the point of concensus, that the mentally ill require medical care as do those who suffer from any somatic illness and that he was optimistic about their prognosis; (b) the man in the street was perfectly able to identify, other than the most "exaggerated deviations" as mental illness, and did identify the simple schizophrenic, the alcoholic, and the juvenile character disorder, and others. An "exemplar of the public" did not place a sizeable social distance between himself and the labelled "mentally ill."

Contradicting this conclusion, Miles' (1981) report, based on his reviews, was that the concepts of "mental illness" and "mental patient" have an unfavorable public image. This, he claimed, had been the evidence of numerous surveys designed to elicit public opinions and attitudes. He pointed out that studies have consistently shown that people evaluate mental illness negatively, reject and discriminate against mental patients, and base their views on traditional stereotypes. He claimed that the public opinion surveys elicited public responses of fear and rejection, far exceeding the intensity responses evoked by physical illness.

It is interesting that Crocetti et al. (1971) were optimistic about the public opinions and attitudes toward mental illness and felt that the public was well informed and was truly sensitive to the needs of the mental patient, while Miles had the opposite reaction. Miles pointed out, though, that the differing research results are not quite

as contradictory as they appear. He referred to the Elinson, Padilla, and Perkins (1967) study where three-quarters of the respondents agreed that unlike physical illness, mental illness tends to repel people, yet only 16% admitted to being repelled themselves, the rest indicating that only others reacted in this way. Miles felt that people might have been responding to the medical view of mental illness which to them is "progressive" and "modern" and hence expected of them. Rootman and Lafave (1969) had also cautioned that attitudes expressed during an interview may not reflect actual behavior toward the mentally ill.

Demographic Correlates of Public Attitude and Information Concerning Mental Illness

As the stigma of the label "mental illness" became widely acknowledged and documented (Rabkin, 1972), researchers began investigating demographic correlates of conceptions of mental illness, and attitude toward it. Ramsey and Seipp (1947) administered a public opinion questionnaire in the field of mental health to 345 individuals in Trenton, New Jersey. The population interviewed was fairly representative according to six background variables of sex, age, race, religion, educational level, and occupational class.

When the responses to the questions were analyzed according to these background factors, the differences revealed that the higher the educational level

(1) the more optimistic the report given concerning the outcome of mental disorders;

(2) the greater the tendency to recommend professional treatment in place of home care;

(3) the more frequently there occurred the qualified response that insanity might be inherited;

(4) the less frequent the association of sin with insanity;

(5) the less the belief in the deleterious effects of associating with the insane; and

(6) the less frequent the response that poor living conditions were a cause of insanity.

The researchers reported that somewhat similar results were found for men, younger age groups, Protestants, and white respondents; and less so for women, older age groups, Roman Catholics, and black respondents. Blacks more frequently associated sin and heredity with causes of insanity.

In Hollingshead and Redlich's (1958) New Haven Community Study, they found that persons in the higher classes held more favorable attitudes toward psychiatrists than those in the lower classes. This inference was supported by the responses of a stratified sample of 517 persons, to questions about their willingness to turn to psychiatrists for help in emotional difficulties. Seven out of eight of the upper class respondents had a fair grasp of the psychiatrist's function; practically all knew he was a medical doctor. Among the lower class, the researchers reported that less than one person in sixteen knew that a psychiatrist was a doctor, and even fewer had more than a vague idea of a psychiatrist's function in society.

Nunnally (1960) pointed out that the favorableness of initial attitudes toward mental illness concepts is unrelated or only weakly related to prominent dimensions of individual differences such as age, sex, education, intelligence test scores, and some measures of personality. However, he pointed out that the correctness of initial information about mental illness/health phenomena corresponds strongly to general sophistication; sophistication being represented by years of formal schooling and intelligence scores.

These results were comparable to those of Rabkin and Suchoski (1967) who investigated mental health views of school teachers and found that teachers, when compared to the public, were better informed about mental illness. Their attitudes, however, were similar to those of the public.

Freeman and Kassebaum (1960), through zero-order correlations and factor analysis of their data on opinions about mental illness, found that the opinions regarding the etiology and prevention of mental illness were only slightly, if at all, related to the level of formal education; and they were only weakly correlated to knowledge of the technical vocabulary.

Clark and Binks (1966), in their analysis, found evidence to support their hypothesis that the younger, more educated, hold more liberal views about mental illness than the older and less educated.

Fischer and Cohen (1972) categorized subjects by social class, educational level, religion, and major in their

investigation of attitude toward seeking psychological help. They used a large sample of high school and college students to test two hypotheses regarding the expected relationship between help-seeking attitude and socioeconomic class.

The first hypothesis was that subjects from upper class families hold more favorable attitudes than subjects from lower class families, particularly among high school and beginning college students (i.e., before education has had an effect). The second hypothesis was that orientations to professional help become more positive as education increases (and, therefore, the discrepancies between people of different class origins diminish with advanced education).

Contrary to the researchers' expectations, they found that social class background had no evident connection to subjects' help-seeking attitude. They found, though, that educational level differences were highly significant. Attitudes of college juniors and seniors were more favorable than college freshmen and sophomores, and college freshmen and sophomores had more positive attitudes than high school students. They found that the effects noted for education were independent of subject's age, so that positive association between education and attitude scores held even within fixed age groups. The obverse relationship (i.e., a correlation between age and attitude with education constant) did not obtain.

In the case of religion, the researchers reported that Jewish subjects tended to express more favorable attitudes than Catholics or Protestants. This more positive attitude of the Jews was present at every socioeconomic level.

In terms of scholastic majors, psychology majors were more positive in their help-seeking attitudes than humanities, hard science, or applied program majors.

Fischer and Cohen (1972), in explaining the "surprise" result as far as "lower class" subjects go, pointed out that the "lower class" persons who participated in the study were atypical representatives of lower class subculture, since many of them, as college or nursing students, were headed to higher societal positions. This, they further pointed out, make it obvious that help-seeking attitudes of working class people are by no means negative or immutable.

This significance of educational level to positive attitude toward seeking psychological help was not surprising to these researchers who made reference to the 1960 study by Gurin, Veroff, and Feld (Americans View Their Mental Health). This report showed that sex, age, and education are consistently related to self-referral measure. Women, young persons, and the more educated have sought psychological help more than any other group. According to the report, the more educated were the largest self-referred group to psychiatrists, as well as to other help sources such as ministers, or nonpsychiatric physicians.

Dohrenwend and Chin-Song (1967) researched social status and attitude toward psychological disorder in relationship to the issue of tolerance of deviance. From their data, they concluded that the appearance of greater tolerance of deviant behavior in low status groups is an artifact of viewing their attitudes within a high status frame of reference. They reported that when both lower and upper status groups define a pattern of behavior as seriously deviant, lower status groups are less tolerant. Also, the relatively tolerant policy of upper status groups appeared to be a consequence of their generally more liberal orientation rather than comprehension of the nature of psychopathology in psychiatric terms.

Changing Ideas of Mental Illness and Its Treatment

Research investigating changes in ideas concerning mental illness and its treatment has parallelled researches on popular conceptions and attitudes. The findings of such investigations have been contradictory and complex. In a study of attitudes toward mental illness in Louisville, Woodward (1951) surveyed a cross-section sample of 3,971 Louisville residents and came to the conclusion that the people (at least in Louisville) were moving toward "a humanitarian and scientific point of view of mental illness and have come quite a long way in that direction" (p. 444). According to Woodward, the old ideas that the mentally ill were

> bad and dangerous and hence to be punished (on the one hand) or were ludicrous and

> silly, and hence to be laughed at (on the other hand) seem to be to a considerable extent superseded by the feeling that mental illness is a sickness that should evoke sympathetic understanding, and that requires some form of professional treatment. (Woodward, 1951, p. 444)

The researcher said she found that the sense of stigma associated with mental illness was passing. She reported that about half of the respondents said they would not hesitate to tell friends and acquaintances about a family member who was mentally ill, "just as if he had heart trouble or asthma." However, she found a gross failure to recognize serious mental symptoms, at least when they were described in words. Woodward hypothesized that it might have been different if the people described were observed.

Woodward also reported a considerable loss of faith in repressive and punitive techniques, especially in dealing with juveniles, and there was no strong negative reaction to the psychiatrist, who she claimed was coming to be regarded as the logical person to handle identifiable cases of mental disorder. She reported that the psychiatrist was also seen as a useful resource in dealing with less serious personality problems, although some stigma was attached to his patients.

Lemkau and Crocetti (1962), like Woodward, had positive response to their attitude studies ten years later, and refuted the widely accepted picture of the social response to mental illness as "essentially rejective and punitive." The researchers claimed that their study, carried out in

Baltimore, was to explore the readiness of a population to accept a program to provide home care for psychiatric patients. They referred to previous studies that showed a tendency to "isolate and reject the mentally ill," but they found that the most common reasons for advocating hospitalization was that respondents felt that a change of environment would be best for both family and patient. This was coupled with the feeling that the families concerned had something to do with the patient's illness, and that the patient might benefit from being away from them.

The findings of Lemkau and Crocetti were confirmed by Dohrenwend and Chin-Song (1967), but Rootman and Lafave (1969) argued that Lemkau and Crocetti had based their conclusion mainly on a comparison of results they obtained in a 1960 Baltimore study with those obtained by Cummings and Cummings (1957) when they investigated the attitudes toward mental illness of a small Canadian town named Blackfoot. Rootman and Lafave also pointed out that Lemkau and Crocetti themselves had raised the possibility that there was something special and different about the Baltimore population that rendered comparability with other populations impossible.

Rootman and Lafave felt that comparison of Blackfoot to another comparable Canadian community--Saltwater--would result in more relevant conclusions concerning attitude change. This comparison of Blackfoot to Saltwater (Rootman & Lafave, 1969) showed that not only did the residents of Saltwater possess more knowledge about mental illness but they also placed less social distance between themselves

and the mentally ill. Rootman and Lafave, however, pointed out that it is quite possible, though unlikely, that urban populations (e.g., Baltimore) have not changed at all in their attitudes and knowledge, that they may always have been more sophisticated about mental illness than rural populations with gradual enlightenment among rural populations an accelerating phenomenon.

Ten years later, Baltimore was researched again. Crocetti et al. (1971) wanted to find out if the attitudinal distance toward mental illness had changed over the years or had remained the same. The prior study of Lemkau and Crocetti (1962) had employed a probability sample of the entire population of Baltimore and had given them Star's (1955) original standard descriptions of a withdrawn schizophrenic girl, an alcoholic man, and a paranoid man. These persons were not identified as mentally ill. Respondents were asked, "do you think X should see a doctor or not?" For the schizophrenic girl, 93% had answered yes. For the paranoid, 96% had answered yes. For the alcoholic, 85% had answered yes.

The study of Crocetti et al. (1971) employed a probability sample of 1,076 from a group of 4,827. Respondents were asked, "do you think people who are mentally ill require a doctor's care just as much as people who have any other sort of illness?" The researchers reported that more than 99% of the respondents answered yes. Other questions dealt with the optimism or pessimism about the outcome of treatment, as

well as questions dealing with attitude toward ex-patients, employing social distance statements such as, "could you imagine yourself falling in love with someone who had been mentally ill?" Using two random samples, a decade apart, and using different question formats, the researchers found evidence that for at least a decade, the public had accepted mental illness as illness. They also looked to the medical profession for treatment of this illness and were optimistic about the outcome of such treatment. The researchers claimed there was no evidence in their study of extreme rejection of the mentally ill by blue collar workers.

In summarizing research on public attitude, Miles (1981) remarked that a general conclusion of the many studies must be that people in Western societies appear to be moving toward greater acceptance of mental disturbance as another illness and toward a lessening of the traditional fear, dislike, and mistrust it implies; but he emphasized that there exists today a large proportion of the lay people who continue to hold the traditional notions.

Relationship of Knowledge and Attitude Toward Mental Illness

Some researchers in this area viewed knowledge as synonymous with education; others confined the term to mental illness information. Even when knowledge is used to include both concepts, research in this area is limited, but directional.

Hollingshead and Redlich (1958) reported that Class I and Class II (the most educated of the population)

respondents in the community he studied, had (with the exception of a few) little knowledge of the principles of dynamic psychiatry before they entered treatment. Even those whose knowledge they rated as fair

> usually knew little more than that psychiatry deals with mental illness and that the psychiatrists heal their patients, not only with drugs and surgery, but also by "mental methods." (Hollingshead & Redlich, 1958, p. 339)

The researchers, however, point out that they were unable to tell just how these "mental methods" work and how emotional stresses and problems are related to emotional and physical problems even after months of psychotherapy.

The educated, though, have consistently been shown to have the most positive attitude toward seeking psychological help (Fischer & Cohen, 1972; Gurin, Veroff, & Feld, 1960; Hollingshead & Redlich, 1958).

Freeman and Kassebaum (1960) found no correlation between formal education and opinions of the etiology and prevention of mental illness. They, however, sanctioned a rash conclusion based on this one analysis that knowledge has little influence on opinions and attitudes toward mental illness. They did, however, caution practitioners associated with mental hygiene and health education programs, in thinking that giving people the facts alters their opinions. They believe that basic research is required into the question of the "frames of reference by which persons integrate factual information and personal opinion" (Freeman & Kassebaum, 1960, p. 47). Such, they claim, would enable

health educators to develop more realistic community mental health programs.

Freeman and Kassebaum cited Shirley Star (1957), who said then that she thought that the primary reason for the failure of mental health education was readily apparent; it was that mental health education had primarily devoted itself to attempting to implant its psychiatrically oriented conclusions into the thinking of people, starting from different premises; these conclusions being mental illness facts without anything about the roots of human personality and behavior.

Rabkin and Suchoski (1967) found that teachers, when compared to the general public, had more "correct" information on mental illness but had similar negative attitudes toward it--again attesting to the irrelevance of information to attitude. This was in agreement with Nunnally's (1961) summary comment that whereas correctness of information correlated to demographic variables such as age and education, correlations between attitudes and such demographic variables are very small. Old people and young people, and people with little formal schooling all tend to regard the mentally ill as relatively dangerous, dirty, unpredictable, and worthless (p. 51).

Phillips (1967) referred to both the studies of Lemkau and Crocetti (1962) and Dohrenwend and Chin-Song (1967) which inferred that the increasing ability of the public to identify mental illness represented a step forward in

public attitude toward the mentally ill. Phillips was not clear why this should be so but thought that if the public increasingly considered mentally ill people to be mentally ill rather than difficult, ill-mannered, bad tempered, or socially deviant, that would in some way help them to become more supportive of those persons.

In an earlier paper, Phillips (1966) had suggested that the increased ability to identify mental illness may have consequences opposite to that cited above, i.e., the person whose behavior is correctly identified as mental illness may as a result be stigmatized and may derive less understanding and support from those around him. To test this hypothesis, Phillips asked a random sample from New Hampshire to respond to three descriptions of mental illness developed originally by Star (1955) and then asked them to respond to a social distance scale which consisted of items such as

1. Would you discourage your children from marrying someone like this?

2. If you had a room to rent in your home, would you be willing to rent it to someone like this?

After the respondents answered the social distance scale questions about each case, they were asked whether the person had some kind of mental illness or not.

The researcher found that the ability to correctly identify those behaviors as mental illness was not associated with acceptance but rather with rejection. He admitted that

the association between identification and rejection did not provide a causal relationship but pointed to two possibilities.

(1) It might have been that respondents strongly rejected those mentally ill individuals on the basis of their objectionable behavior, and then when asked whether or not they considered them mentally ill, responded affirmatively to support their earlier negative evaluation.

(2) Because respondents had already identified those descriptions of mentally ill people (i.e., when first encountering the descriptions, and prior to answering the social distance scale questions), they rejected them strongly based on this identification.

Phillips finally concluded that these findings did not support the conclusions of Dohrenwend and Chin-Song, nor those of Lemkau and Crocetti that the ability to identify mental illness represents a step forward in public attitude toward the mentally ill.

Altrocchi and Eisodorfer (1961), after investigating the proposition that attitude change may occur as a function of increased information, reported that the results of their study did not support this proposition. They used didactic instruction about mental illness and obtained attitudinal reactions to abstract concepts like "insane man" through semantic differential scores.

This lack of relationship between knowledge and attitude was also exemplified when a French and a non-French

Canadian town were compared (Lafave, Rootman, Sydha, & Duckworth, 1967). It was found that the more "enlightened" and "sophisticated" community manifested less tolerant behavior toward the mentally ill. Over one-third of the adult population of the community signed a petition to reject the establishment in the community of a halfway house for former residents of the town who had been hospitalized in the state mental hospital.

The researchers reported that in contrast, the residents of the "unenlightened" and "unsophisticated" town had been most cooperative in the establishment and operation of three foster homes for patients, some of whom had never been residents of the community.

Yamamoto et al. (1967), in their study of college student teachers, had them indicate their mental health attitudes in response to case descriptions on a questionnaire. The main hypothesis was that among subjects of roughly similar socioeducational level, rejection of the mentally ill, expressed in terms of social tolerance, and suggested helpsource, is a function of (a) type of described case, (b) sex of described case, and (c) sex of respondent.

These researchers, granting weakness to the use of questionnaire case descriptions to approximate actual behavior, found little to indicate any influence of training and education upon the mental health attitudes of teachers.

Dixon (1967) compared attitude change after completion of psychology courses. He found some favorable attitude

changes but subsequent interviews with the instructors led him to believe that the instructor's attitude had greater effect on the students' attitude than did the content of the text used. This is more in agreement with other reports that imparting information about mental illness does not, by itself, alter attitudes of the general public (Rabkin, 1972).

Cross-Cultural Attitudes and Conceptions Concerning Mental Illness

The clinical approach to mental illness supports the notion that except for superficial variation in content, psychiatric disorders are viewed as fundamentally the same (Townsend, 1978). Based on this approach, Kiev (1969) suggested that the difficulties inherent in cross-cultural study of mental illness can be overcome by intensive studies of a single culture.

The sociocultural approach to mental illness is supported by those who contend that behavior disorders vary cross-culturally because they are molded by the particular stresses and strains of a given society. There is also the belief that virtually no act is inherently abnormal; cultural context and more define what is normal or abnormal (Benedict, 1934).

Gallagher (1980) espoused a similar view. He stated that there is an important relationship between mental illness and the wider social forces commonly known as culture. From his perspective, culture influences the very way mental illness is defined; the same behavior can be considered

healthy or normal in one culture and ill or abnormal in another.

In Scheff's (1960) analysis of mental disorders as social roles, he stated that both before and after public labeling, the popular conceptions of mental illness which have been learned and culturally reinforced since childhood govern the expectation of the rule-breaker and those around him and force his behavior into increasing conformity with popular conceptions. The theory thus proposes that a culture's conception of mental illness largely determines the process of defining someone as mentally ill. This definition process acts as a self-fulfilling prophesy, that is, through inadvertent reinforcement from the social environment, the deviant's symptomology ultimately comes to resemble the popular stereotypes. In this process, the stereotypes function as "guidelines for action," both for the deviant and for the laymen and professionals who react to him.

Relating Scheff's theory to this cross-cultural variation, Townsend (1978) proposed that one would make the following predictions.

Proposition I. Two different cultures with different conceptions of mental disorders will show differences in professional conceptions which correspond to differences in the two cultures' popular conceptions.

Proposition II. Mental patients' views of mental disorders will show differences which correspond to differences in popular conceptions.

Proposition III. Differences in symptom formation in these two cultures will correspond to differences in popular conceptions.

Germany and America were chosen for the study because their cultural similarities, according to the researcher, would limit the number of variables and thus make comparisons more useful and because previous studies had suggested that conceptions of mental illness differed significantly in the two countries (Nunnally, 1961).

Nunnally's sixty-item questionnaire (1961, pp. 259-264) was utilized to assess conceptions of mental illness in Germany and America. This instrument was chosen because the researcher thought that it would facilitate comparison with Nunnally's data and because the questionnaire items had been derived from a broad spectrum of popular and professional conceptions and then subjected to a considerable array of validation procedures.

Townsend used students and mental hospital staff and patients to test his hypotheses. The results showed that mental health professionals in Germany and America resembled their lay compatriots in their conceptions of mental disorder more than they resemble each other. Americans, in contrast to Germans, tended to endorse the notions that mental disorders are environmentally induced and can be influenced by an individual's personal effort and will power. Americans differed significantly from Germans ($p < .001$) in response to the question, "how can you recognize a mentally ill

person?" More Americans cited stereotyped, bizarre physical characteristics as "diagnostic criteria." In contrast, the Germans more frequently favored "internal" criteria; that is, they tended to cite disturbances of mental functions, cognition, and judgement as characterizing mental illness.

Mental patients' conception in Germany and America generally parallelled the conceptions held by professionals and students in their own country.

Two studies compared Anglo-Americans' and Mexican-Americans' perception of mental illness. Edgerton and Karno's (1971) investigation was an effort to determine whether the under-representation of Mexican-Americans in both private and public psychiatric facilities throughout the southwestern states could be related to differences in their perceptions of, or attitude toward mental illness. The research method was by survey interview in which were included eight vignettes representing a variety of diagnostic categories. Three tentative and general conclusions were drawn by the researchers.

1. The underutilization of psychiatric facilities by Mexican-Americans (at least those who reside in east Los Angeles) could not be accounted for by the fact that they share a cultural tradition which caused them to perceive and define mental illness in a significantly different way than do Anglos.

2. It did not seem that the under-representation in psychiatric facilities reflected a lesser incidence of

mental illness than that found in other ethnic populations in this country.

3. The under-representation in psychiatric treatment facilities is to be accounted for by a complex of social and cultural factors. These factors have very different weightings in their relative influence. Some of the heavily weighted factors include a formidable language barrier, the significant mental health role of the very active family physician, the self-esteem reducing nature of agency-client contacts experienced by Mexican-Americans, and the marked lack of mental health facilities in the Mexican-American community itself.

Factors of moderate weighting are such considerations as open border across which return significant numbers of Mexican-Americans seeking relief of emotional stress, and the perceived threat of "repatriation" attached to a variety of institutions and agencies of the dominant society. Lesser weight is attributed to factors such as "folk-medicine," "folk psychotherapy," and "Mexican culture."

Parra (1980) also did a comparative study of Mexican and Anglo-Americans' perception of and attitude toward mental illness. Five short vignettes characterizing people were employed to tap respondents' perception of mental illness. Among the questions, the most important, as assessed by the researcher, was whether they would classify the case in question as mental illness.

Attitude toward mental illness was measured by a social distance scale, tapping high to low tolerance of the mentally ill. The study revealed that a substantial difference existed between Chicanos and Anglos with regard to perceptions of mental illness and attitude toward the mentally ill.

When relationship of demographic variables to perception of and attitude toward mental illness among Mexican-Americans were analyzed in Edgerton and Karno's investigation, age, sex, religion, education, occupation, and number of years in the United States barely approached statistical significance.

Parra's study, on the other hand, showed age and perception of mental illness to be significantly related. The younger Chicano tended to view mental illness within a narrower framework than the older. The older Chicano, in turn, was not much different from the Anglo. Among Anglos, age made no difference. Education played a primary role in differentiating Chicano perception of mental illness. The young and the less educated were most likely to perceive fewer behaviors as mental disorder.

With regard to attitude, Parra found that the young Chicanos tended to be the most tolerant toward the mentally ill. The older Chicanos, in contrast, tended to be the least tolerant.

One study (Sue, Wagner, Davis, Margullus, & Lew, 1976) investigated conception of mental illness among Asian and Caucasian American students. The purpose of the study was

to investigate ethnic differences in beliefs and conceptions of mental illness. Nunnally's (1961) questionnaire was used. The researchers felt that this questionnaire would indicate differences related to Asian subcultural values or minority group status. Subjects were also asked for number of credits taken in psychology courses; the prior enrollment in an abnormal psychology course; the level of educational attainment achieved by their father, their mother, and themselves; their ethnicity; age; sex; and marital status.

Through the use of partial correlation, the researchers examined ethnic differences in belief toward mental illness, after all the other background factors (educational level, parents' education, age, sex, etc.) were controlled. The partial correlations yielded six significant relationships. Asian-Americans were more likely than Caucasian students to believe that too much sex can cause personality problems; a mentally healthy person does not become overly angry at minor insults; in order to be well adjusted, people should openly talk to others about all of their problems and secrets; children who are well adjusted should not talk back to their parents; it is better for children if their father rather than their mother makes most of the big decisions; and families are better off psychologically if the mother rather than the father is closer to the children. There was a tendency for subjects to disagree, but with the Caucasian students disagreeing more strongly than the Asian-American students.

A controversial scale used in clinical diagnosis is the MMPI (Minnesota Multiphasic Personality Inventory). Several studies have reported distinctive differences in the MMPI's of blacks and whites. Most of these studies, though, have concentrated on establishing personality differences (Harrison & Kass, 1967; Jones, 1978). Gynther (1972), in his review of the literature on the use of MMPI on blacks and whites, wondered if this was not a "prescription for discrimination." He pointed out that differences in social-desirability ratings of items and a disproportionate representation of black-favored items on the key scales partially accounted for those findings. He believed that education, residence, and cultural separation had some influence on the degree of difference found.

Coie, Constanzo, and Cox (1976), fully cognizant of the previous use of MMPI on black and white respondents and resulting controversies, explored behavioral determinants of mental illness by comparing two community subcultures. A stratified sample (race, sex, and social class) of 469 laymen from two North Carolina communities responded to a 190-item MMPI-based questionnaire with the degree of mental illness concern evoked by each item.

According to the researchers, the results reflected systematic race and social class differences in the behavioral bases. Black subjects expressed greater mental illness concern than white subjects on the clusters which indexed social introversion, suspicion and mistrust,

disruptive thoughts, and personal inadequacy. Whites scored higher than blacks on the drug and alcohol abuse cluster and on the thought disorder cluster.

Lower class respondents showed greater mental health concerns than either middle or upper class respondents on the clusters which indexed social introversion, suspicion and mistrust, and personal inadequacy. Both lower and middle class subjects scored higher than upper class respondents on the resentment and aggression cluster. Middle class subjects showed greater concern than upper or lower class respondents on items reflecting drug and alcohol abuse. Both upper and middle class subjects showed significiantly greater concern on the thought disorder and destructive tendency clusters than the lower class respondents.

Gynther (1972) had suggested that the most satisfactory results from the use of the MMPI would be those obtained from an MMPI normed on blacks. If this concern is a valid one, then the results of Coie et al. (1976) would have to be deemed tentative.

Ring and Schein (1970) examined the attitude toward mental illness and the use of caretakers in a black community called Cobbs Creek, in west Philadelphia. The researchers reported that from the sample of 388 households, the general trend in attitude responses was in the direction of acceptance and understanding. They claimed that respondents agreed strongly with items representative of an enlightened mental health viewpoint and disagreed strongly with

factually inaccurate, prejudicial, and negative statements. Respondents expressed willingness to associate with ex-patients as fellow workers, club members, and neighbors; but some reluctance was displayed to accepting an ex-patient as a roomer and to having an ex-patient marry a member of the respondent's family.

Only a negligible number of respondents favored consultation with a nonmedical caretaker if faced with a mental or emotional problem. Nearly 90% reported an intention to utilize medical personnel in such a case.

Utilization of Mental Health Facilities by Blacks

Results of Ring and Schein (1969), reported in the section above, appeared to be the exception rather than the rule when the utilization of mental health facilities by blacks is examined.

Tucker (1979) pointed out that mental health clinicians, psychiatrists, and psychologists consistently report a very small black clientele. This researcher felt that a deterring factor to seeking counseling is the blacks' attitude toward white mental health professionals, whom they do not perceive as being capable of helping them solve their problems. In her investigation, she explored the attitudes of blacks toward seeking professional counseling, and attitudes toward black and white psychiatrists and psychologists as possible factors in underutilization as well as to identify changes needed to increase utilization.

Tucker found that, in general, blacks made little or no use of mental health facilities. Only 8% of the blacks, compared to 40% of the whites sampled had made use of these facilities. Of the 8% of the blacks who had used these clinics, only 2.5% reported liking the people there. Apart from negative evaluation of the facilities and service providers, Tucker suggested several other factors that contributed to underutilization. These included lack of information concerning the existence of these facilities, the kind of service offered, and simply not having felt the need for such services.

Regarding the perceptions that blacks have of psychiatrists and psychologists, Tucker reported that respondents in the lowest income group (14%) viewed these providers' roles as that of "dealing with crazy people," but the majority did not share this view and felt that all kinds of people would be helped with various kinds of emotional problems.

An interesting finding by Tucker was that 90% of blacks interviewed believed that whites had more need for psychiatrists and psychologists and that blacks are stronger and more tolerant of hardships due to their history of oppression.

One pervasive factor brought out by the results of this study was the awareness of the feeling of discomfort if others knew they were seeing a psychiatrist or psychologist; yet 62% would not stigmatize others who were clients. This, as the researcher pointed out, was an unawareness or unwillingness to acknowledge the negative feelings they have toward seeking help from a psychiatrist or psychologist.

Another consistent result across all socioeconomic levels was the attitude of blacks toward seeking help from white therapists. The researcher reported that 66% of the respondents said they would prefer a black therapist, while 12% of this 66% stated that they would not even talk to a white therapist.

Tucker pointed out implications for increasing the utilization of mental health services by blacks. These were the need for better publication in the black communities of the locations, fee rates, and kinds of available services of nearby mental health clinics; need to establish the fact that seeking psychological help is neither degrading nor a sign of weakness; the need for the importance of mental health and signs of unhealthy behavior to be taught in schools; and the need for more visible black mental health professionals.

Kenneth Davis and Jacqueline Swartz (1972) pointed out that the patterns of underutilization of college mental health services are similar to those of community services, in that both are underused by black people who are seen mainly at crisis points. They claimed that for many black people, going for mental health services is a ready admission of being crazy. This is in agreement with Tucker's (1979) finding. For black males, the suggestion that they are not coping effectively with their lives touches highly sensitive areas of identity and masculinity. For black females, the concern of femininity does not seem to be as

much of an issue, as anxiety over not being able to deal adequately with problems, handle crises, and arrive at appropriate solutions.

Davis and Swartz also pointed out that most black people do not come into contact with psychiatric clinics unless overtly disruptive, psychotic, or arrested. Psychiatry is often viewed as a punitive profession and is frequently associated with social or medical agencies, and identified with invasions of privacy and no regard for confidentiality. Then there are the clinics themselves with cumbersome intake procedures and derogatory prerequisites. They further stated that if treatment is initiated, the therapist will most likely be white and will probably be viewed as an alien person who is unable to understand the personal and sociological pressures that are obvious and inescapable to a black person. The white person will be thought of as part of the white power structure--an authority figure whose orientation and training will most probably mean a long, tedious analytical process. Tucker's (1979) study brought out the preference by blacks for black therapists who they thought would better understand them.

In a study on ethnic groups' perception of mental health service providers, Schneider, Laury, and Hughes (1980) provided an example of an effort to pinpoint factors influencing the utilization of mental health facilities by minorities. This study assessed male and female Chicanos, blacks, and Anglo college students' perception of one hundred characteristics

of six service provider groups and the likelihood that subjects would discuss problem areas with them.

The analysis revealed that blacks and Chicanos were more likely than Anglos to take personal problems to professionals. Students preferred to consult psychiatrists and clinical psychologists for the same types of problems more than counseling psychologists, who in turn were preferred more than college counselors, high school counselors, and advisors. For educational-vocational concerns, students generally expressed a stronger probability of consulting providers other than psychiatrists and clinical psychologists.

The five characteristics that most consistently discriminated the providers were analytic, curious, intellectual, knowledgeable, and persistent.

Webster and Fretz (1978) reported no difference between sexes or among ethnic groups in comparing college students' preferences for help-giving sources. Schneider et al.'s study revealed that both sex and ethnic status, in addition to the specific service provider, influence community college students' preferences. Schneider et al. believed that the discrepant findings between the two studies might be explained by the fact that their study was restricted to professional providers, whereas Webster and Fretz's list of help sources included specific helpers as well as generic help agencies.

Schneider et al. also explained that the fact that Chicanos and blacks reported they they were more likely than Anglos to discuss personal problems with professional groups

may be due to the fact that Anglos, being more familiar with mental health professionals, know that they can hurt as well as help. Another possibility they offered was that minorities experience more difficulties and/or are more concerned about their difficulties; or that Chicanos and black students would simply have been motivated to breach personal problems with providers since minorities are disposed to "gaming" or telling an interviewer what he/she wants to hear (Harrison, 1975).

Schneider et al., however, acknowledged several limitations of the study, one being that the subjects were community college students in the southwest, and that results found in multiracial research to some extent reflect the pattern of race relations that exist at that particular time and in that particular part of the country.

Studies on factors influencing lower class black patients remaining in therapy have been done by several researchers. One such was Anthony Vail (1976). He studied the problem of early termination in an inner city community mental health clinic. His hypothesis concerned similarities between patients and therapists that would foster ongoing relationships, and also black patients' attitude toward whites and how relatable their therapists appeared to them. Sex was found to be the only significant variable in the effect of patient-therapist similarity on continuation in therapy. Attitude toward whites had no effect on continuation, nor did therapist characteristics and patient-therapist similarity of views of treatment. Vail concluded that, based

on the result of this study, it seems as if negative attitudes on the part of blacks may not always be directed against the white professionals but against the white establishment and their facilities; but Tucker (1979) believes attention needs to be given to the attitudes of blacks toward white professionals. Sue et al. (1974) pointed out that blacks and the poor themselves may fail to utilize mental health facilities due to negative attitude toward the facilities as well as to factors such as difficulty in obtaining transportation, release time from work, etc.; and they may begin therapy and prematurely terminate for any of these reasons.

In the studies so far cited, the analyses have been on clients who actually started therapy, and the assessment of therapist variables and client perception of and attitude toward service providers. There have also been studies that have researched the need for mental health care as an effort to understand underutilization. One such was by the North Central Florida Community Mental Health Center (Miller, 1980). Respondents from the black community in Gainesville, Florida, were interviewed in an effort to assess their need, and resource utilization in their community. When asked to whom they would refer a friend or family member experiencing a "nervous breakdown," 30% of the respondents said they would refer them to a doctor, 16.7% would recommend the community mental health center, 12.8% suggested the emergency room, 12% did not know who they would recommend, and 10% would suggest a family member, friend, or neighbor. Only 3.7%

said they would recommend the Crisis Center. The Crisis Center was, however, the referral of choice for 20.1% in answer to the question, "if a friend or family member came to you and said they felt life was not worth going on with, who would you urge them to see?"

In an effort to assess the reasons for underutilization of the Alachua County Crisis Center by Gainesville's black community, the researchers found that 52% of the respondents in their study had heard of the Crisis Center, and of those, only 14% had used it. The reason given by those who had heard about it but had not used it was that they had no need of its services. So one of the reasons for underutilization was that 48% of respondents did not know of the Crisis Center's existence. They found that those who had used it were, on the average, younger with more education and income and were more likely to be employed.

Other areas researched have been the inequities in the delivery of services to blacks and the poor. These inequities, according to Sue et al. (1974), may occur at several levels: (a) blacks or poor clients may be denied treatment because of discriminatory institutional policies or because of the cost of treatment, (b) they may be admitted to mental health facilities but receive inferior forms of treatment compared to other clients, (c) traditional forms of therapy may be applied equally to all clients but be inappropriately applied without due consideration to cultural background or lifestyle of these clients, and (d) blacks and the poor themselves

may fail to utilize mental health facilities due to negative attitudes toward them.

In this particular study by Sue et al., they examined the services received by black clients in the community mental health care system. They found a high utilization of services relative to the proportion of blacks residing in the area studied. There was no evidence that blacks, compared to whites, received inexpensive or inferior types of treatment. In fact, they reported that blacks were slightly more likely than whites to engage in individual therapy, an expensive mode of treatment. However, the problem was that black clients, more often than whites, were seen by paraprofessional staff at the intake session and during therapy. The results persisted even when racial differences in demographic characteristics were eliminated.

The researchers found that although the magnitude between the type of staff and the variables examined were small, race had the strongest relationship with black clients having a more difficult time than whites in receiving psychiatrists, psychologists, and social workers. They were concerned about whether staff assignment was another form of discrimination whereby black clients are shuffled to staff members who are relatively poorly paid, ineffective, or inexperienced. They, however, did voice the opinion that they doubted that the facilities had any formal policies that discriminate, and that the extent of the informal discrimination was perhaps a factor in the therapists' preference.

Sue et al. (1974) were particularly disturbed by the finding that over half of the black clients failed to return for therapy after the first session. The precise explanation for the high dropout rate could not be determined. They added that, if as indicated by previous studies that black clients are usually seen by white therapists, and such racial differences often impede the development of trust and rapport, then the early termination was understandable.

Sue (1977), in a later research, found that Asian-Americans, Chicano, and native Americans who tended to receive treatment equal to that of white clients, also had poor outcome as measured by premature termination rates. He admitted that minority groups do show considerable differences in utilization patterns so that generalizations based upon a nonwhite category may be inappropriate.

Some black and white differences in utilization were analyzed by Sue, McKinney, Allen, and Hall (1974). This was based on 13,450 clients seen at seventeen community mental health facilities. Information was obtained on clients' demographic background, diagnostic assessment, type of treatment received, type of personnel rendering treatment, and number of contacts. The analysis compared 959 blacks with 10% or 1,190 randomly selected whites.

Demographic Characteristics

In the case of blacks, males were more likely to seek treatment than females, while the opposite was true for whites. The sex difference between blacks and whites was

significant (X^2 = 24.50, df = 1, < .001). Income, education, and age were examined by a 2 (race) x 2 (sex) analysis of variance. Blacks had a lower income than whites with sex, and race x sex interaction being nonsignificant. With respect to education, blacks were lower than whites, and males were lower than females. The race x sex interaction was not significant. The main effects of race and of sex were significant for age, with whites and females, respectively, being older. Among females, blacks were less likely to be married than unmarried when compared to whites. Thus, according to the results, blacks represented a quite different type of clients than whites from the outset.

Type of Service

Although over 90% of all clients received inpatient or outpatient programs, the researchers reported that there was a tendency for blacks to be assigned less frequently for outpatient than inpatient programs in comparison to white clients, even after the effects of all demographic variables were partialed out. They reported that there was no evidence of blacks receiving inexpensive or less preferred services since no differences emerged in individual psychotherapy, which had been used as an indicator of discrimination against blacks.

Type of Personnel Seen

Consistent differences were found in the type of personnel performing the intake and rendering treatment to black and white clients. Blacks were more often seen at

intake by paraprofessionals (including other personnel) and less often by professional specialists (psychiatrists, psychologists, and social workers). This was so even after the effects of other demographic variables were partialed out.

Contact With Facilities

In this study, the researchers analyzed for race and other factors of clients who returned or failed to return after the initial session, as well as for the actual number of contacts (not including the initial session). When examination was made of clients who failed to return after the initial contact with the facilities, a striking racial difference was found. Fifty-two point one percent of the black clients dropped out of therapy as compared with 29.8% of the whites, a difference that was significant ($X^2 = 110.29$, $df = 1$, $p < .001$). After the researchers eliminated the influences of other demographic variables and service, blacks were still more likely than whites to discontinue after the initial session.

The researchers wondered if blacks had been less severely disturbed than whites and therefore saw little need to continue in therapy. They, however, dismissed this as not being likely since blacks (13.8%) were no more likely than whites (12.7%) to receive a diagnosis of psychoses.

One of the limitations to generalization of the finding (as pointed out by the researchers themselves) was the confinement of the study to one geographic area--the greater Seattle (King County) area.

Another study done in a different geographic area was that comparing minority students seen by a black psychotherapist (Lester Alston) with a randomly selected group of white students during the academic year 1969-1970. The purpose of the study was to determine if there were differences between the minority and nonminority students seen by the therapist in their utilization of the psychiatric unit of the Health Service. Did minority students come to the Health Service via the same routes as nonminority students? Did they differ in stated reasons for coming as judged by their presenting problems? Was their utilization of the service, such as number of visits and returns, similar to that of other students?

The researcher found that 75% of the nonminority students were self-referred compared to 44% of the minority students. Nearly half the minority students seen were referred by counselors, administrative officials, or faculty; while just 11% of the nonminority students were. A large percentage of minority male students were staff-referred while none of the white men and just four of the white women were staff-referred.

Minority students (41%) exceeded nonminority students (21%) in percentages citing situational and cultural factors as primary factors in their difficulty. A larger number of nonminority students presented themselves initially on the basis of symptomatology despite the fact that there was no appreciable difference between the groups in the

number referred by physicians and nurses from the Medical Service.

In reviewing the issue for further utilization of the service, the researcher found that more minority students seen, returned for service at a later point than nonminority students, although the difference was not significant. What was interesting was that minority students who initially presented themselves by identifying a behavior problem of recurrent or repeated nature were somewhat more likely to return than nonminority students who focused on situational and cultural factors in their initial presentations.

The researcher felt that the difference between samples in those returning probably reflected an interaction at some level between the therapist and the client, with the minority students feeling more comfortable in returning (although they all did not) than the nonminority students.

Another interesting speculation of the researcher was the fact that minority students would not focus on neurotic symptoms initially, but it seemed must cope with ambivalences and resistances about seeing a "shrink" over and beyond those experienced by the average nonminority student. That such a large number of minority students presented initially in situational or cultural terms, raised the question, the researcher felt, of whether after presenting his/her distress as fortuitous and transient (situational) or inevitable and unsolvable (cultural) was subsequently able to engage the problem at levels of insight and understanding

necessary to derive some therapeutic benefits from the contacts.

None of the minority students who presented "cultural" factors in the initial presentations were self-referred. The researcher found that even this initial cultural presentation did not seriously limit the range of materials these students offered the therapist. This tendency, he felt, of minority students to emphasize situational and cultural factors in initial presentations was interpreted as an attempt to cope with ambivalence, but did not seem to be a barrier to more insightful discussion of their problems.

A study highlighting some of the complexities involved in interpreting utilization studies is exemplified by research by Goodman and Siegel (1978). This research investigated differences in white/nonwhite community mental health center service utilization patterns.

The researchers routinely collected computerized data which were used to study the process of service delivery in terms of admission patterns, type, and quantity of services rendered, and status at termination for whites and nonwhites in two community mental health centers with substantial nonwhite populations. A total of 2,946 clients were studied. Social area analysis techniques were employed to control for socioeconomic status, ethnicity, and lifestyle variables; and an epidemiological model was used to analyze admission and service delivery rate differences.

The researchers found that nonwhite admission rates were at least twice as great as white rates. Service delivery rates to the population at large were considerably greater for nonwhites than for whites. Delivery of direct services within the centers differed for whites and nonwhites, but no consistent trends emerged when types and amounts of services rendered were analyzed, controlling for sex, ethnicity, age, diagnosis, and social area. Disruption of case indices was greater for nonwhites than for whites.

Comer (1973), in summarizing the problem of utilization of mental health facilities by blacks, discussed various facets involving the mental health needs of blacks. He pointed out that many blacks are reluctant to see white therapists, but that qualified black therapists are in short supply. Blacks, however, he continued, suffer the full range of mental illnesses and need the full range of mental health services. Tucker (1979) shared this concern, stating the need for more visible black mental health clinic workers. This visibility and availability, whether or not they are more effective in working with black clients, are conducive, she feels, to blacks' at least coming to clinics and therapy offices so that black and white mental health professionals will have a chance to counsel them.

Tucker (1979), in her investigation of blacks' definitions of mental health as a factor in their underutilization of mental health services, found that many blacks accept a wider range of behaviors as being mentally healthy than

whites, who have established the standard of mental health. She found that 51% of her interviewees gave definitions "in harmony with the idea of mental illness" in her assessment of personal definitions of mental health, while 21% responded in the direction of mental health. Tucker remarked that since she had no comparable data from whites, it was not conclusive that blacks have a unique conceptualization of mental health.

Summary of the Literature

Over the past several years, mental health researchers have investigated conceptions of mental illness and attitude toward the mentally ill and their treatment. Their investigations ranged from popular conceptions of respondents from different geographic areas throughout the country to more specific populations such as mental patients, mental health professionals, students, and teachers.

The general finding was that knowledge about mental illness has increased over the years. The results on attitudes have been somewhat conflicting with some researchers claiming that attitude toward mental illness has become more positive while others report that negative stereotypes still exist to a large extent.

When the relationship between knowledge and attitude was investigated, the over-riding finding was that knowledge about mental illness bore little, if any, relationship to attitude toward mental illness and its treatment. There was the expressed need for further research on the "frames of

reference by which persons integrate factual information and personal opinion" (Freeman & Kassebaum, 1960, p. 47).

However, when demographic variables were investigated in relationship to attitudes, those in the higher socio-economic strata, the more educated, the younger, and females tended to have more positive attitudes toward mental illness, the mentally ill, and toward seeking psychological help.

Studies, researching blacks' attitudes and opinions concerning mental health providers, mental health facilities, and attitude toward being mentally ill, have all been attempts to understand factors responsible for their underutilization of mental health facilities.

Although a few studies have been aimed specifically at understanding other minorities' conceptions of mental illness, there has been no detectable study reported on blacks' conceptions of mental illness on a comparative basis with whites. The same holds true for a comparative study of blacks' and whites' attitudes toward seeking psychological help. There is a need for such a study in order to better understand underutilization of mental health facilities by blacks.

CHAPTER 3

RESEARCH METHODOLOGY

Overview

The purpose of this study was (1) to determine the relationship of ethnicity to attitude toward seeking psychological help, (2) to determine the relationship of ethnicity to conceptions of mental illness, and (3) to determine if a relationship existed between attitude toward seeking psychological help and conception of mental illness. The study included a sample of 321 white and 192 black school teachers employed by the Alachua County School Board in Florida.

Conceptions of mental illness and attitude toward seeking psychological help and the relationship between attitude and conception were investigated through a descriptive research design. All subjects were administered a Demographic Information Questionnaire, the Nunnally Conception of Mental Illness Questionnaire, the Fischer and Turner Pro-Con Attitude Scale, and vignettes on counseling problems and issues.

The remainder of this chapter will be concerned with (1) hypotheses, (2) data collection procedure, (3) selection of subjects, and (4) the instruments used.

Hypotheses

Hypothesis I

Help-seeking attitudes are related to ethnicity and not to other demographic factors.

Hypothesis II

Conceptions of mental illness are related to ethnicity and not to other demographic factors.

Hypothesis III

Attitudes toward seeking psychological help are related to conceptions of mental illness.

Data Collection Procedures and Selection of Subjects

Six hundred and sixty-nine school teachers employed by the Alachua County School Board of Florida were randomly selected from the 1983 Directory containing 1,300 full-time employed teachers. Of those selected, 269 were black and 400 were white. Each was sent by mail a packet containing (1) Explanation (Appendix A), (2) Informed Consent (Appendix B), (3) Instructions (Appendix C), (4) Demographic Information Questionnaire (Appendix D), (5) Nunnally Conception of Mental Illness Questionnaire, (6) Fischer and Turner Pro-Con Attitude Scale, and (7) vignettes. An addressed stamped envelope was also included in each packet.

It was expected that the teachers would require approximately 30 minutes to complete all the instruments in the packet. Participation in the study was on a voluntary basis, and this was stated in the explanation to the teachers. Incentive to participate was the offer to have participants

who desired this to be informed of the results at the completion of the study. Ninety percent of the respondents requested this information.

It was expected that there would be a return rate of 50% of the entire sample. There was a return of 76.9%; with 80% for whites (321) and 71% for blacks (192). The final sample was 513 from the original 669 selected.

Instruments

The instruments used in this research were the Fischer and Turner Pro-Con Attitude Scale, the Nunnally Conception of Mental Illness Questionnaire, vignette case examples, and a Demographic Information Questionnaire.

Fischer and Turner Pro-Con Attitude Scale

This scale was developed by Edward Fischer and John Turner of the Psychology Department of Connecticut Valley Hospital, Middletown, Connecticut (1970). The scale consists of sixteen randomly selected items of the original 29. Attitude statements, according to Fischer and Turner, were written in collaboration with several clinical psychologists who were familiar with numerous mental health settings including state and federal hospitals, clinics, and private practice and school situations. They felt that the items selected sampled many aspects of the general orientation toward seeking professional help for psychological problems. Judges rated each item as to its relevance to the hypothetical attitude domain and according to whether it reflected a positive or negative attitude. Judges consisted of a

panel of fourteen clinical and counseling psychologists and psychiatrists.

The instrument utilizes a five point Likert format with responses ranging from one (strongly disagree) to five (strongly agree). Negative items were reversed for scoring. A high score indicated a positive attitude toward seeking psychological help.

The internal reliability of the scale (Tyron's 1957 method) computed for the standardization sample of n = 212 was reported by Fischer and Turner to be .86. The reliability estimate was .83 computed on a later sample of 406 subjects. Five groups of students were given the scale twice at varying intervals to establish test-retest reliabilities. The attitude scores remained stable over time: $r = .86$ ($n = 26$), $r = .89$ ($n = 47$), $r = .82$ ($n = 31$), $r = .73$ ($n = 19$), $r = .84$ ($n = 20$).

None of the items correlated greater than .25 with social desirability scores neither in anonymous nor identifiable conditions. Factor analyses revealed four dimensions. Factor I identifies a recognition of personal need for psychotherapeutic support. The subject scoring low on this subscale sees little necessity for professional help for emotional problems, believing that psychological conflicts resolve themselves. The high scorer is in favor of seeking help for his emotional stress. Factor II includes items which assess the subjects' opinions about the threat of stigmatization as a result of psychiatric treatment. The high

scorer expresses freedom from such concerns. Factor III refers to items in which subjects display interpersonal openness with a willingness to reveal themselves to appropriate professionals. Factor IV involves confidence in mental health professionals.

In addition to the sixteen items (four from each dimension), a seventeenth item--developed by the researcher--was included. This asked subjects whether they had in the past used psychological services.

Nunnally's Conception of Mental Illness Questionnaire

The conception of mental illness questionnaire was developed by Jim Nunnally in 1960. The construction of the instrument involved initially over 3,000 opinion statements by members of the public, by experts, and in the mass media. Samples of expert opinions were gathered from mental hygiene books, professional publications, and over 200 public information pamphlets, as well as from personal interviews, magazines, etc. The more than 3,000 statements were related to causes, symptoms, prognosis, treatment incidence, and social significance of mental health problems. By reduction of duplicates, the questionnaire was reduced to 60 items which include the following ten components.

1. The mentally ill are characterized by identifiable actions and appearances.

2. Will power is the basis of one's personal adjustment.

3. Women are more prone to mental illness than are men.

4. If one can avoid morbid thoughts, he/she can avoid mental illness.

5. If one can obtain support and guidance from stronger persons, he/she can avoid mental illness.

6. One who is mentally ill is in a hopeless condition.

7. Mental disorders are caused by immediate environmental pressures.

8. Emotional difficulties are not matters of great concern.

9. Older people are more susceptible to mental illness.

10. Mental illness is attributable to organic factors.

The scale used in this research consisted of 20 of the original 60 items. Two items were randomly chosen from each factor, e.g., Factor I: "The insane laugh more than normal people." Factor II: "Will power alone will not cure mental disorders."

The instrument utilizes a five point Likert format with responses ranging from one (strongly disagree) to five (strongly agree). Subjects are asked to choose one of the five categories as a response to the items. The higher the individual score, the greater the misconceptions about mental illness. Nunnally's scale has been widely used in assessing mental health conceptions (Sue et al., 1976; Townsend, 1978).

Vignettes

Ten vignettes based on concepts derived from counseling literature, cross-cultural counseling, and research on

utilization of mental health facilities were developed by the researcher. These investigated the subjects' opinions concerning the following issues.

1. Culture of the therapist versus culture of the client.

2. Private practice versus community mental health service.

3. Problem types and the efficacy of seeking treatment.

4. Race of the therapist versus race of the client.

5. Socioeconomic difference between client and therapist.

Each of the ten items had five response alternatives: strongly agree, agree, neutral, disagree, strongly disagree. Each item was given a score from one to five, with five representing the most liberal views on the five issues investigated.

Demographic Information Questionnaire

This questionnaire was administered to subjects in order to obtain the following information: race, age, sex, marital status, income, religion, highest education obtained, subject being taught by teacher, place of birth, and where educated. The first seven named variables were an integral part of the analyses.

CHAPTER 4

RESULTS

This study was designed to investigate whether conception of mental illness and attitude toward seeking psychological help were related to ethnicity and not to other demographic variables. This study was also designed to examine the relationship of conception of mental illness to help-seeking attitude, and if race was a significant factor among subjects who had received psychological help in the past. The population studied consisted of black and white school teachers employed by the Alachua County School Board in Florida. The demographic variables considered most relevant with respect to the study were (1) sex, (2) age, (3) marital status, (4) highest education obtained, (5) religion, (6) income, and (7) race. This chapter will be divided into two sections; (1) description of the sample and (2) results related to the hypotheses.

Description of the Sample

The sample consisted of 513 school teachers employed by the Alachua County School Board in Florida. Of these, 62.57% were white and 37.43% were black. There were 23.19% males and 76.81% females. Subjects in the 20-39 age group comprised 59.44% of the total sample: those in the 40-59 age group comprised 37.44%, while 31.12% were in the over 60

age group. Distribution of these subjects by race are shown in Table 1. Single subjects comprised 15.40% of the total sample, with 64.72% married, 18.13% divorced, and 1.75% widowed. A breakdown by highest education obtained by the subjects revealed 2.14% with less than a bachelor's degree, 40.16% with a bachelor's degree, 20.07% with master of arts degree, 28.0 % with master in education degree, and 1.56% with a doctorate degree. Distribution of these subjects by race are shown in Table 2.

Breakdown into religion revealed that 63.16% were Protestants, 11.89% were Catholics, 2.92% were Jewish, and 43% belonged to none of the above religions. Income ranged from $8,000 to over $16,000 with 1.5% receiving between $8,000 and $10,000, 2.73% receiving between $10,000 and $12,000, 13.65% receiving between $12,000 and $14,000, and 62.96% receiving over $16,000. Table 3 shows the distribution of these subjects by race.

Teachers were primarily employed at the elementary, middle, or high school levels with 48.73% at the elementary level, 19.11% at the middle school level, 28.46% at the high school level, and 3.70% not affiliated with any of the above levels. Both blacks (77.6%) and whites (76.3%) were involved in teaching subjects other than Social Science, Humanities, Hard Science, and Biology. These other courses included Music, Physical Education, and Mathematics.

A larger proportion of the white sample (67%) were born in a non-Florida state compared to blacks who had only 23%

Table 1

Distribution of Subjects
by Race, Sex, and Age

	Race			
	Whites	% of Total Whites	Blacks	% of Total Blacks
Sex				
Males	77	24.00	42	22.00
Females	244	76.00	150	78.00
Age				
20-39	187	58.00	118	62.00
40-59	120	38.00	72	37.00
Over 60	14	4.00	2	1.00

Table 2

Distribution of Subjects
by Race, Marital Status, and Highest Education

	Race			
	Whites	% of Total Whites	Blacks	% of Total Blacks
Marital Status				
Single	39	12.15	40	20.83
Married	218	68.00	114	59.38
Divorced	60	18.70	33	17.19
Widowed	4	1.25	5	2.60
Highest Education				
Less than BA	7	2.18	4	2.08
BA	124	38.62	82	42.71
MA	95	29.60	49	25.52
M.Ed.	90	28.04	54	28.13
Ph.D.	5	1.56	3	1.56

Table 3

Distribution of Subjects
by Race, Religion, and Income

	Race			
	Whites	% of Total Whites	Blacks	% of Total Blacks
Religion				
Protestant	213	66.36	111	57.81
Catholic	53	16.50	8	4.17
Jewish	12	3.74	3	1.56
None of the above	43	13.40	70	36.46
Income				
$ 8,000-$10,000	0	0.00	3	1.56
$10,000-$12,000	11	3.43	3	1.56
$12,000-$14,000	43	13.40	27	14.06
$14,000-$16,000	58	18.06	45	23.44
Over $16,000	209	65.11	114	59.37

of non-Floridians. Also only 14.6% of the black sample received their higher education in a state other than Florida, compared to 31% of the whites. Appendix E gives additional information on the distribution of subjects by race and selected variables.

Results Related to the Hypotheses

Hypothesis I

It was hypothesized that help-seeking attitudes, as measured by the Fischer and Turner Attitude Scale are related to ethnicity and not to other demographic variables. The other demographic variables considered were sex, age, marital status, highest education obtained, religion, and income. A hierarchical multiple regression analysis was executed on the attitude scores. The controlled variables were entered first and race entered last. The relevant test was the increase in the variance explained by race over and above that explained by the previous entered variables. The results are reported in Table 4. For the entire group, the mean score on the attitude instrument was 56.516. Blacks had a mean of 56.159 and whites had a mean of 56.730. The hierarchical multiple regression analyses indicated that race was not a significant factor in help-seeking attitude. Thus, the hypothesis that ethnicity is related to help-seeking attitude is rejected.

Hypothesis II

It was hypothesized that conception of mental illness is related to ethnicity and not to other demographic variables.

Table 4

Regression Analysis of Attitude Scores

Attitude	N	Mean	Standard Deviation
Whites	321	56.7305	7.5660
Blacks	192	56.1592	6.8410
Total	512	56.516	7.2978

Source	df	Sum of Squares
Model	7	1729.946
Error	505	25538.098
Total	512	27268.044

$R^2 = 0.0634$

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Sum of Squares	Probability > |T|
Sex	1	-3.0428	0.7582	-4.013	814.280	0.0001*
Age	1	0.3559	0.5976	0.596	17.9337	0.5518
Marital Status	1	0.6650	0.5130	1.296	84.9791	0.1955
Highest Education	1	0.0725	0.3802	0.191	1.8399	0.8488
Religion	1	-0.2942	0.2672	-1.101	61.3144	0.2714
Income	1	1.0775	0.4156	2.592	339.820	0.0098*
Race	1	-0.3317	0.6641	-0.500	12.6198	0.6176

*p > .05.

As a first test of this hypothesis, the Nunnally Conception of Mental Illness Questionnaire was administered to respondents. The demographic variables considered were sex, age, marital status, highest education obtained, religion, and income. A hierarchical multiple regression analysis of the conception scores was employed. The controlled variables were entered first and race was entered last. The increase in the variance explained by race over and above that explained by the previous entered variables is the test of significance of race. The results are reported in Table 5. The mean score for the entire sample was 47.734, while the blacks had a mean of 49.370 and the whites had a mean of 46.754. Scores for blacks ranged from 36 to 62. Scores for whites ranged from 32 to 57. Lower scores depicted less stereotypic conceptions of mental illness, with conceptions closer to those of professionals in the field of mental health. The hierarchical multiple regression indicated that race was a significant variable in conceptions of mental illness.

In order to determine which of the ten components of the conception scale was race significant, each component was separately analyzed by hierarchical multiple regression with the same demographic variables of sex, age, marital status, highest education obtained, religion, and income entered first and race entered last. The mean scores and standard deviation for the component scores for each component for blacks and whites are depicted in Table 6.

Table 5

Regression Analysis of Conception Scores

Conception	N	Mean	Standard Deviation
Whites	321	46.7536	4.4487
Blacks	192	49.3704	5.0606
Total	512	47.7342	4.8505

Source	df	Sum of Squares
Model	7	898.896
Error	505	11147.441
Total	512	12046.337

$R^2 = 0.0746$.

Variable	df	Parameter Estimate	Standard Error	Sum of Squares	T for HO: Parameter = 0	Probability > |T|
Age	1	0.0811	0.5009	0.0513	0.162	0.8714
Sex	1	0.5613	0.3948	19.9003	1.422	0.1558
Marital Status	1	-0.1010	0.3389	8.1262	-0.293	0.7657
Highest Education	1	0.0012	0.2512	0.3002	0.005	0.9960
Religion	1	0.2328	0.1765	139.209	1.319	0.1878
Income	1	0.0273	0.2740	0.3873	0.100	0.9006
Race	1	2.5249	0.4387	730.932	5.754	0.0001*

*p > .05.

Table 6

Descriptive Statistics for Conception Component Scores for Whites and Blacks

Whites (n = 321)

Components	Mean	Standard Deviation
Look and act different	4.3917	1.2010
Will power	6.0725	1.0273
Sex distinction	5.6613	0.9608
Avoidance of morbid thoughts	5.0621	0.2601
Guidance and support	5.0893	1.2580
Hopelessness	7.2157	1.4032
External versus personality	5.7399	1.2341
Nonseriousness	1.5029	0.6519
Age function	6.1840	0.9880
Organic causes	4.8979	0.9924

Blacks (n = 192)

Components	Mean	Standard Deviation
Look and act different	5.1432	1.4763
Will power	6.4184	1.1767
Sex distinction	5.9466	1.1429
Avoidance of morbid thoughts	5.8946	1.1538
Guidance and support	5.9650	1.3280
Hopelessness	7.0921	1.7235
External versus personality	5.9148	1.3666
Nonseriousness	1.6822	0.6616
Age function	6.0721	0.9174
Organic causes	5.1365	1.0384

Table 7 shows the effect of race after controlling for the other demographic variables in the hierarchical multiple regression analysis. The increase in variance explained by race over the controlled variables was significant in the following components: (1) look and act different, (2) will power, (3) sex distinction, (4) avoidance of morbid thoughts, (5) guidance and support, (6) nonseriousness, and (7) organic cause. A more detailed description of the component analysis is offered in Appendix F.

A second test of the second hypothesis was the analysis of subjects' response to ten vignette items that explored their opinions on the following issues: (1) culture of the therapist versus culture of the client, (2) private practice versus community mental health service, (3) problem types and the efficacy of seeking treatment, (4) race of the therapist versus race of the client, (5) socioeconomic differences between client and therapist. Hierarchical multiple regression was used to determine if race was a significant variable in the responses. Other demographic variables controlled for were sex, age, marital status, highest education obtained, religion, and income. These were entered first. Then, race was entered last. The relevant test was the increase in the variance explained by race over and above that explained by the previously entered variables. The results are depicted in Table 8. Race was significant in the following components: (1) child problem--whether or not parents having problems disciplining their child should seek counseling,

Table 7

Regression Analyses of Race in Conception Components

Component	Variable	df	Parameter Estimate	Standard Error	Sum of Squares	T for HO: Parameter = 0	Probability > |T|
Look and act different	Race	1	0.7468	0.1225	63.9513	6.093	0.0001*
Will power	Race	1	0.3511	0.1013	14.1346	3.464	0.0006*
Sex distinction	Race	1	0.2782	0.0963	8.8795	2.889	0.0040*
Avoidance of morbid thoughts	Race	1	0.8884	0.1852	90.5040	4.795	0.0001*
Guidance and support	Race	1	0.8818	0.1201	89.1571	7.341	0.0001*
Hopelessness	Race	1	-0.2036	0.1423	4.7620	-1.432	0.1528
External versus personality	Race	1	0.1805	0.1203	3.7362	1.500	0.1343
Nonseriousness	Race	1	0.1671	0.0605	3.2044	2.761	0.0060*
Age function	Race	1	0.0712	0.0898	0.5827	-0.795	0.4280
Organic causes	Race	1	0.1941	0.0913	4.3236	0.115	0.0349*

*p > .05.

Table 8

Regression Analyses of Responses to Vignettes

Component	Variable	df	Parameter Estimate	Standard Error	Sums of Squares	T for HO: Parameter = 0	Probability > |T|
Similar culture of client and therapist	Race	1	0.1473	0.0888	2.4876	1.659	0.0978
Any culture of client or therapist	Race	1	0.0592	0.0770	0.4023	0.769	0.4421
Sex problem	Race	1	-0.0344	0.0744	0.1363	-0.463	0.6436
Child problem	Race	1	0.2574	0.0783	7.5998	3.285	0.0011*
School boy problem	Race	1	-0.0921	0.0884	0.9726	-1.042	0.2980
Race difference of client and therapist	Race	1	0.2538	0.0830	7.3905	3.057	0.0024*
Socioeconomic difference of client and therapist	Race	1	0.1368	0.0653	2.1482	2.095	0.0367*
Private practice choice	Race	1	0.0462	0.0723	0.2454	0.640	0.5225
Community clinic choice	Race	1	0.0166	0.0772	0.0319	0.216	0.8291
Socioeconomic discomfort	Race	1	0.0166	0.0772	0.0319	0.216	0.8291

*p > .05.

(2) race difference of client and therapist--if therapist of one race can truly understand a client of another race, and (3) socioeconomic difference of client and therapist--if a therapist of a middle socioeconomic status can relate to and understand the problems of a lower socioeconomic status client. The scores were also analyzed for the mean and standard deviation on each item for each group (Table 9). Blacks were more liberal (gained higher scores) than whites on items that dealt with mixed race and cross-cultural counseling. However, blacks scored lower than whites on the items that dealt with the efficacy of psychological treatment for the sex problem and the child problem presented.

It was assumed that conceptions of mental illness that parallel those of mental health professionals should result in the utilization of mental health facilities. To test this, a third measure of conception of mental illness in relation to ethnicity was therefore the analysis of the responses subjects gave to whether or not they had received therapy in the past. The responses to such a question revealed that 27.41% of the white subjects and 14.58% of the blacks had received psychological counseling in the past. The demographic variables controlled for in a hierarchical multiple regression were age, sex, marital status, highest education obtained, religion, and income. These controlled variables were entered first. Race was entered last. The relevant test was the increase in variance explained by race over and above that explained by the previously entered

Table 9

Descriptive Statistics for Vignette Scores for Whites and Blacks

Whites (n = 321)

Components	Mean	Standard Deviation
Similar culture of client and therapist	2.3407	0.8364
Any culture of client or therapist	2.6532	0.7551
Sex problem	3.7451	0.7549
Child problem	1.6210	0.7687
School boy problem	3.9741	0.9711
Race difference of client and therapist	2.1151	0.7680
Socioeconomic difference of client and therapist	2.0565	0.6397
Private practice choice	1.8937	0.7672
Community clinic choice	4.0680	0.8225
Socioeconomic level discomfort	1.8723	0.6417

Blacks (n = 192)

Components	Mean	Standard Deviation
Similar culture of client and therapist	2.5185	1.1155
Any culture of client or therapist	3.6897	0.9457
Sex problem	3.6496	0.9040
Child problem	1.9033	0.9691
School boy problem	3.8901	0.9115
Race difference of client and therapist	2.3792	1.0551
Socioeconomic difference of client and therapist	2.1709	0.7881
Private practice choice	1.9476	0.7909
Community clinic choice	4.0863	0.8335
Socioeconomic level discomfort	2.0654	0.7426

variables. Race was significant in having sought therapy in the past (Table 10).

Hypothesis III

It was hypothesized that attitudes toward seeking psychological help are related to conceptions of mental illness for both whites and blacks. The first test of this hypothesis was the employment of a hierarchical multiple regression analysis on the attitude scores controlling for the following variables: age, sex, marital status, highest education obtained, religion, and income. These variables were entered first, then conception scores were entered last. The relevant test was the increase in the variance explained by conception over and above the previously entered variables. Conception was significant variable at the $p > .01$ level of significance. This was the case for both whites and blacks (Tables 11-A and 11-B). A negative regression coefficient for both blacks and whites indicated that there was a significant negative correlation between attitude and conception. As attitude scores increased (denoting positive attitudes toward seeking therapy), conception scores decreased (denoting less stereotypic, and more professionally oriented conceptions of mental illness).

Conception scores were also analyzed in relation to the scores on the vignette items and the therapy items in order to ascertain the significance of conception to the responses given by blacks and whites. For those who had, or had not been in therapy, conception was not a significant variable

Table 10

Regression Analysis of Therapy Scores

Source	df	Sum of Squares	Mean Square	F Value	Probability > F
Model	7	8.7178	1.245	1.377	0.2117
Error	505	456.641	0.9042		
Total	512	465.359			

R^2 = 0.0187.

THERAPY

Variable	df	Parameter Estimate	Standard Error	Sums of Squares	T for HO: Parameter = 0	Probability > |T|
Sex	1	-0.006027	0.046478	0.0017	-0.130	0.8969
Age	1	0.042873	0.036633	0.0409	1.170	0.2424
Marital Status	1	-0.066345	0.031445	1.0287	-2.110	0.0354
Highest Education	1	-0.023939	0.023304	0.1142	-1.027	0.3048
Religion	1	0.026795	0.016379	0.8442	1.636	0.1025
Income	1	0.015361	0.025479	0.0722	0.603	0.5469
Race	1	0.097873	0.025479	1.0982	2.404	0.0166*

*p > .05.

Table 11-A

Regression Analysis of Attitude Scores
with Conception Scores for Whites

Source	df	Sum of Squares	Mean of Squares	F Ratio	Probability > F
Model	7	4228.037	604.005	13.444	0.0001
Error	313	14062.074	44.9267		
Total	320	18290.111			

R^2 = 0.2312.

Variable	df	Parameter Estimate	Standard Error	Sums of Squares	T for HO: Parameter = 0	Probability > |T|
Sex	1	-5.5170	0.8886	1599.528	-6.208	0.0001
Age	1	-0.2882	0.6762	0.030	-0.426	0.6702
Marital Status	1	0.9920	0.6507	227.495	1.525	0.1284
Highest Education	1	0.9246	0.4547	234.591	1.813	0.0708
Religion	1	0.5384	0.3671	69.281	1.466	0.1436
Income	1	0.3808	0.4929	45.526	0.773	0.4404
Conception	1	0.5586	0.0847	1951.585	-6.591	0.0001*

*p > .05.

Table 11-B

Regression Analysis of Attitude Scores
with Conception Scores for Blacks

Source	df	Sum of Squares	Mean of Squares	F Ratio	Probability > F
Model	7	1966.589	280.941	7.414	0.0001
Error	184	6972.129	37.8920		
Total	191	8938.718			

R^2 = 0.2200.

Variable	df	Parameter Estimate	Standard Error	Sums of Squares	T for HO: Parameter = 0	Probability > |T|
Sex	1	1.2205	1.1225	28.001	1.087	0.2784
Age	1	2.8820	0.9603	677.402	2.999	0.0031
Marital Status	1	0.4340	0.6857	1.849	0.633	0.5276
Highest Education	1	-1.1748	0.5392	148.440	-2.179	0.0306
Religion	1	-0.8032	0.3297	433.076	-2.434	0.0159
Income	1	1.4070	0.6143	169.211	2.290	0.0231
Conception	1	-0.3301	0.0901	508.609	-3.664	0.0003*

*p > .05.

among both whites and blacks. Conception was, however, differentially significant for whites and blacks on the vignette items. Results are shown in Table 12.

Summary of the Results

The findings demonstrated that

1. When race was considered along with other demographic variables, race was not a significant factor in attitude toward seeking psychological help as measured by the Fischer and Turner Pro-Con Attitude Scale.

2. When race was considered along with other demographic variables, race was a significant variable in conception of mental illness as measured by the Nunnally Conception of Mental Illness Questionnaire.

3. Race was significant in the differences in responses to the ten vignettes which investigated opinions on the efficacy of problems deserving psychological treatment, views on cross-cultural and cross-racial dyads in counseling and preference for certain counseling setting. Blacks scored higher (more liberal) on items that dealt with issues such as mixed race, and cross-cultural dyads, but scored lower than whites on items that dealt with the efficacy of problems deserving psychological intervention.

4. There was a significant relationship of conception of mental illness to attitude toward seeking psychological help even when other demographic variables were considered. This was true for both whites and blacks. Multiple regression coefficient depicted a significant negative correlation

Table 12

Regression Analyses of Conception Scores with Vignette Scores for Whites and Blacks

Whites

Components	df	Parameter Estimate	Standard Error	Sums of Squares	T for HO: Parameter = 0	Probability > |T|
Child problem	1	0.9080	0.3246	152.478	2.797	0.0055*
Race difference	1	1.1845	0.3222	258.772	3.676	0.0003*
Socioeconomic difference of client and therapist	1	1.0421	0.3886	140.425	2.682	0.0077*
Private practice choice	1	0.9276	0.3232	160.291	2.870	0.0044*
Community clinic choice	1	-0.7935	0.3028	134.200	-2.620	0.0092*
Socioeconomic discomfort	1	1.7436	0.3843	385.755	4.536	0.0001*

Blacks

Components	df	Parameter Estimate	Standard Error	Sums of Squares	T for HO: Parameter = 0	Probability > |T|
Similar culture of Client and therapist	1	0.7155	0.3325	114.553	2.152	0.0327*
Sex problem	1	-1.0989	0.4238	164.545	-2.593	0.0103*

*p > .05.

signifying that as attitude became more positive (higher scores), conception became less stereotypic (lower scores).

5. When race was considered along with other demographic variables, race was a significant variable in having received therapy in the past.

6. Conception of mental illness was significantly related to responses on the vignette items for both whites and blacks, but moreso for whites.

7. Conception of mental illness was not significantly related to whether or not these teachers had received therapy. This was true for both blacks and whites.

CHAPTER 5

DISCUSSION

The purpose of the present study was to investigate the relationship of ethnicity to conceptions of mental illness and attitudes toward seeking psychological help among school teachers, and to examine the relationship of help-seeking attitudes to conceptions of mental illness. It was hypothesized that conceptions of mental illness and attitudes toward seeking psychological help are related to ethnicity and not to other demographic variables. It was also hypothesized that there is a relationship between attitude toward seeking help and conceptions of mental illness.

Review

Attitude Toward Seeking Psychological Help

The results of this study did not indicate that ethnicity was a significant variable in attitude toward seeking psychological help. The demographic variables considered were sex, age, marital status, highest education obtained, religion, income, and race. The fact that ethnicity was not a significant variable might possibly be due to subjects responding in a socially desirable manner, being aware of how to portray a positive attitude toward seeking psychological help.

Conception of Mental Illness

Ethnicity was significant in conception of mental illness. Other demographic variables considered were sex, age, marital status, highest education obtained, religion, and income. The conception scale was a measure of information on mental illness with the higher scores indicating the presence of more stereotypic beliefs rather than factual information. Race was significant in seven of the ten components of the scale.

When Nunnally (1960) researched public conceptions of mental illness, he asserted that he could foresee only two possible results: (1) that the public was "misinformed" in the sense that the "average" man held numerous misconceptions about mental illness, or (2) that the public was "uninformed" in the sense that the average man had little information, correct or incorrect, about many of the problems. His results showed that "the average man was not grossly misinformed" (Nunnally, 1960, p. 232). Rabkin and Suchoski (1967), using Nunnally's conception questionnaire in their investigation of school teachers' conception of mental illness, reported that teachers were reasonably well informed concerning mental health problems, and that the differences between teachers and experts were relatively small. These studies did not compare blacks' conceptions with those of whites'. Sue et al. (1976) did compare whites' responses with those of Asian-Americans. After controlling for demographic and background variables of 62 Asian-Americans and 81

Caucasian college students, arrived at a number of significant ethnic differences which they interpreted in the context of Asian subcultural values.

Black teachers in this study were more likely than whites to believe that the mentally ill look and act differently than normals, that will power can cure mental disorders, that women are more likely than men to suffer from mental illness, that mental illness can be controlled by the avoidance of morbid thoughts, and that guidance and support of strong persons in the community are needed to maintain mental health. Black subjects moreso than white subjects endorsed the nonseriousness of emotional problems and the physical etiology of mental illness.

These differences may be related to the differences in the historical and cultural experiences of blacks and whites, which have resulted in different world views on a basic issue.

Vignettes

The results of the analysis on the vignettes showed that race was a significant factor in the responses made by the subjects. Whites were more likely than blacks to approve of counseling for problems related to sex, parenting, and truancy in a school child; but blacks more strongly than whites endorsed cross-cultural counseling believing that these could be just as effective as any other counseling dyad. They superceded whites in their endorsement of cross-racial dyads, and believed more than whites did that socioeconomic differences between therapist and client were important.

Based on these results, it seems that blacks are more liberal than whites in their views where counseling issues are concerned, but are less likely than whites to see certain specific problems as needing psychological intervention. This "lack of need" might very well be rooted in the dynamics of conception of mental illness, which in turn might be an explanation for underutilization of mental health facilities by blacks. Tucker (1979), in her research on underutilization of mental health facilities by blacks residing in Long Island (New York), reported that 71% of the respondents reported not ever having the need for psychological help.

Therapy

Race was a significant variable when responses to the item asking subjects whether or not they had used psychological services in the past were analyzed. A proportionately higher number of whites than blacks had used psychological services in the past. It is possible that the differences may be explained by differences in cultural perceptions. Tucker (1979) reported that 40% of those interviewed believed that fewer blacks go to psychiatrists because as a race they are a more tolerant and stronger people. She explained that this "greater tolerance and strength" usually focused on the history of blacks as an oppressed group. This resulted in their having learned to endure stress, unlike whites who "react more catastrophically to it." Seeking therapy might, therefore, be interpreted by blacks as a sign of weakness.

Relationship of Attitude to Conception

A significant negative correlation was found between attitude and conception. In essence, as attitude scores became more positive (increased), conception scores became less stereotypic (decreased). This was the trend for both blacks and whites. The significance of the relationship of attitude and conception showed by analysis that conception was a significant variable of attitude for both blacks and whites. It would seem that if blacks and whites have similar attitudes but differ in conception of mental illness, then underutilization might be due to this difference in conceptions of mental illness. The analysis of the therapy responses in this study did not show conception to be a significant variable. This might be due to the pressure on blacks to seek therapy in certain stiuations even though their conceptions of mental illness remain different from those of whites. The vignette component scores, however, attested to the significance of conception of mental illness in the opinions expressed by the two groups. Conceptions of mental illness was significant for whites in six of the ten items while for blacks conception was significant in only two of the ten items. This difference is significant.

Implications

The results of this study have both theoretical and practical implications that need to be addressed. If the differences in conception of mental illness are rooted in cultural differences, then important issues need to be raised

concerning definitions of mental illness and intervention strategies. If, as suggested by one of the components on the conception scale that blacks feel that will power can cure mental illness, then it is not surprising that blacks who perceive themselves as "strong" will have difficulty adopting the role of a client, a position which could easily be perceived as a "weak" one. If, as suggested by another component that blacks feel that guidance and a strong community support can maintain mental health, then the greater importance of church pastors in the black community for emotional support (Miller, 1980) over psychologists and psychiatrists should not be surprising.

Much of the research on black underutilization of mental health facilities have focused on cross-racial counseling dynamics, and attitude toward white professionals. The results of this study call attention to conceptions of mental illness that need to be considered when underutilization of mental health facilities by blacks is explored.

There are also several implications for further research. It is necessary that further research into black and white teachers' attitudes and conceptions continue in order to assess and monitor the findings, to determine whether or not the results of this study hold across different regions in the country. It will also be necessary for other black and white groups to be researched enabling more global statements to be made concerning the results.

There is also need to experiment with the idea that unlike what has been demonstrated in this study, the difference in conception of mental illness is not due to ethnic factors but to some other variable not investigated here.

Research is needed to empirically establish the fact that underutilization of mental health facilities by blacks is indeed related to conceptions of mental illness.

Further research is needed to improve and refine the instruments for ascertaining for blacks and whites more reliable measurement of attitude toward seeking psychological help, and conceptions of mental illness.

Limitations and Methodological Assumptions

Although a number of significant findings emerged, certain limitations need to be considered.

1. There was no control group or comparison groups; therefore, results were limited to teachers employed by Alachua County School Board.

2. There was uneven sample sizes between black and white teachers, with the smaller number of blacks being a higher percentage of black teachers employed by the county.

3. There was the possibility that subjects responded in a socially desirable manner rather than in a manner that reflected the subject's own attitudes and conceptions. There was an effort to minimize this by the anonymity of the responses.

It had been assumed that the voluntary nature of participation in the study had no significant effect upon the

outcome. It had also been assumed that both black and white school teachers belonged to the same socioeconomic class.

Conclusions

Based on the findings and limitations of this study, it would appear that several conclusions are warranted. This study suggests that black and white school teachers have similar attitudes toward seeking psychological help. This was true when other demographic variables such as age, sex, marital status, highest education obtained, income, and religion were evaluated along with race.

This study also reveals that conceptions of mental illness is related to ethnicity and not to other demographic factors. This needs to be considered as a factor in cross-cultural counseling. It might also have important implications for the traditional mental illness model which does not take cultural differences of conceptions of mental illness into consideration.

A possibility that can be tentatively suggested is that underutilization of mental illness by blacks might be related to their conceptions of mental illness. However, if blacks are to feel completely satisfied with services they receive at mental health facilities, these services must be compatible with blacks' cultural values and beliefs. Underutilization of mental health facilities by blacks has always been a valid concern of mental health professionals, but so too should be their awareness of cultural differences in conception of mental illness. Further research into this

area could ultimately lead to the formulation of a mental illness model that makes allowance for cultural differences.

Author's Reflections on the Study

The results of this study were particularly interesting to the researcher who during many years of experience with clients, noticed that blacks who came in for therapy were rarely self-referred, and on those occasions when they were, they were in a crisis situation. Whites, on the other hand, were more often than not self-referred, and their presenting problems covered a much wider spectrum that included parental conflicts, relationship problems with friends, depression, as well as organic and functional psychotic complaints. Blacks' conception of mental illness seemed to lie in a narrower framework.

The inception and development of the research topic was a result of these observations; and the findings of this study have paved the way for future research which could build upon and compliment the present study.

APPENDIX A

EXPLANATION TO PARTICIPANTS

I am asking school teachers of elementary, middle, and high schools in Alachua County to participate in a research study which concerns conception of mental illness and attitude toward seeking psychological help. Your name was chosen on a random basis and permission to ask you to participate has been granted by Dr. Mel Lucas, Director of Research and Evaluation of the Alachua County School Board.

The response you give to the items will be kept confidential and anonymous. Once your questionnaires have been received by this researcher, your name will be erased and replaced by a number. No other person will have access to the information you give. The data collected will be used for statistical analyses only.

Participation in this research is voluntary, but will provide major contributions to the field of mental health research in general and to the Board of Education in particular. Your participation will make you eligible to be informed of the findings. If you wish to be informed, please indicate this on the attached stub and I will forward to you, by mail, the results of this study.

Name _____

I wish to be informed of the findings of this study.

APPENDIX B

INFORMED CONSENT

Conception of Mental Illness and Attitude Toward Seeking Psychological Help

Because school teachers' roles as educators are so important in our society, investigators are constantly researching their attitudes, views, and responses in a wide variety of investigations. Mental health practitioners are also interested in your views and opinions on mental illness. This study concerns your conception of mental illness and attitude toward seeking psychological help. Your participation requires approximately 35 minutes to respond to the items.

All parts of the study are strictly confidential within the legal limits of the law. Noone other than the researcher will have access to any of the material. To ensure anonymity, please do not write your name on any of the instruments. Demographic information such as age, sex, race, and income are for statistical purposes only.

By responding to the items, you will have the benefit of becoming aware of your own opinions and attitudes toward mental illness and will also be informed of the results if you so desire. If you are participating, please respond to the items and return the package to the researcher as soon as possible.

Please feel free to ask any questions that you may have at this time.

Lena Hall
Graduate Student
Psychology Department
University of Florida

APPENDIX C

INSTRUCTIONS

This packet contains material which is being used to collect information on concept of mental illness and attitude toward seeking psychological help. All of this information will be kept strictly confidential and anonymous, and will be used for statistical purposes only.

Please answer all the items. If any of the possible answers do not completely represent your knowledge or feeling, please indicate the best possible choice for you. You may allow yourself thirty minutes to respond to these items. Do not deliberate too long over any one item, since there are no correct or incorrect responses.

The first instrument is the Demographic Information Questionnaire which takes three minutes to complete. The second is the Case Examples. This takes five to six minutes to complete. The other two instruments are the Nunnally Conception Scale and the Fischer and Turner Attitude Scale, each of which takes eight to ten minutes.

Upon completion of these instruments, you are asked to mail them in the addressed and stamped envelope included in the packet. Your responses will be confidential and anonymous.

Thank You,

Lena Hall
Graduate Student
Psychology Department
University of Florida

APPENDIX D

DEMOGRAPHIC INFORMATION QUESTIONNAIRE

1. Sex:

   Male ___ Female ___

2. Age:

   20-39 ___

   40-59 ___

   Over 60 ___

3. Marital Status:

   Single ___

   Married ___

   Divorced ___

   Widowed ___

4. Education:

   Less than BA ___

   BA ___

   MA ___

   M.Ed. ___

   Ph.D. ___

5. Religion:

   Protestant ___

   Catholic ___

   Jewish ___

   None of the above ___

6. Race:

   White (not Hispanic) ___

   Black (not Hispanic) ___

7. Income:

   $ 8,000-10,000 ___

   10,000-12,000 ___

   12,000-14,000 ___

   14,000-16,000 ___

   Over $16,000 ___

8. Place of Birth:

   City _____

   State _____

9. School of Employment:

   Elementary ___

   Middle ___

   High ___

   Other (please specify)

   _____

10. Subject Taught:

Social Science ___

Humanities ___

Hard Science ___

Biology ___

Other (please specify)

_____

11. Highest Education Obtained in:

City _____

State _____

APPENDIX E

DISTRIBUTION OF SUBJECTS BY RACE AND SELECTED VARIABLES

	Race			
	Whites	% of Total	Blacks	% of Total
School of Employment				
Elementary	149	29.04	101	19.69
Middle	57	11.11	41	7.99
High	102	19.88	44	8.58
Other	13	2.53	6	1.17
Subject Taught				
Social Science	18	3.51	15	2.92
Humanities	19	3.70	10	1.95
Hard Science	8	1.56	6	1.17
Biology	31	6.04	12	2.34
Other	245	47.76	149	29.04
State of Highest Education				
Florida	219	42.70	164	32.00
Non-Florida State	102	19.88	28	5.40
State of Birth				
Florida	99	19.30	146	28.46
Non-Florida State	215	41.91	45	8.77
Foreign Country	7	1.36	1	.19

APPENDIX F

REGRESSION ANALYSIS OF CONCEPTION COMPONENT SCORES

Look and act different

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	0.1736	0.1399	1.240	0.2154
Age	1	0.3627	0.1103	0.329	0.7424
Marital Status	1	-0.0397	0.0946	-0.420	0.6750
Highest Education	1	-0.0355	0.0701	-0.506	0.0025
Religion	1	0.0265	0.0493	0.539	0.5903
Income	1	0.1059	0.0767	1.380	0.1681
Race	1	0.7468	0.1225	6.093	0.0001*

Will power

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	-0.1319	0.1157	-1.140	0.2547
Age	1	0.0737	0.0912	0.808	0.4195
Marital Status	1	0.1229	0.0783	1.570	0.1170
Highest Education	1	-0.0169	0.0580	-0.292	0.7708
Religion	1	0.0131	0.0407	0.322	0.7475
Income	1	0.0243	0.0634	0.383	0.7017
Race	1	0.3511	0.1013	3.464	0.0006*

Sex distinction

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	0.1584	0.1099	1.440	0.1505
Age	1	-0.0332	0.0866	-0.383	0.7016
Marital Status	1	0.0137	0.0744	0.185	0.8533
Highest Education	1	0.0547	0.0551	0.993	0.3213
Religion	1	0.0313	0.0387	0.808	0.4193
Income	1	0.0724	0.0602	1.201	0.2303
Race	1	0.2782	0.0963	2.889	0.0040*

*p > .05.

Hopelessness

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	0.0190	0.1625	0.117	0.9067
Age	1	-0.0355	0.1280	-0.277	0.7816
Marital Status	1	-0.0360	0.1099	-0.328	0.7431
Highest Education	1	0.1278	0.0814	1.569	0.1172
Religion	1	0.1485	0.0572	2.593	0.0098
Income	1	-0.0390	0.0890	-0.438	0.6617
Race	1	-0.2038	0.1423	-1.432	0.1528

External versus personality

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	-0.0402	0.1374	-0.293	0.7695
Age	1	0.1655	0.1083	1.528	0.1270
Marital Status	1	0.0452	0.0929	0.487	0.6267
Highest Education	1	0.0103	0.0689	0.151	0.8803
Religion	1	0.0068	0.0484	0.142	0.8869
Income	1	-0.0598	0.0753	-0.794	0.4275
Race	1	0.1805	0.1203	1.500	0.1343

Avoidance of morbid thoughts

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	-0.9011	0.2115	-4.260	0.0001
Age	1	0.2882	0.1667	1.728	0.0845
Marital Status	1	0.0134	0.1431	0.094	0.9249
Highest Education	1	-0.1555	0.1060	-1.466	0.1433
Religion	1	0.1784	0.0745	-2.393	0.0171
Income	1	0.1602	0.1159	1.382	0.1676
Race	1	0.8884	0.1852	4.795	0.0001*

*p > .05.

Guidance and support

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	0.0472	0.1371	0.344	0.7308
Age	1	0.0318	0.1081	0.295	0.7884
Marital Status	1	-0.1424	0.0927	-1.535	0.1254
Highest Education	1	-0.0752	0.0687	-1.094	0.2745
Religion	1	-0.0291	0.0483	-0.604	0.5463
Income	1	-0.0175	0.0751	0.234	0.8150
Race	1	0.8818	0.1201	7.341	0.0001*

Nonseriousness

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	0.2583	0.0691	3.737	0.0002
Age	1	0.0156	0.0545	0.287	0.7743
Marital Status	1	0.0067	0.0467	0.144	0.8859
Highest Education	1	0.0270	0.0346	-0.781	0.4352
Religion	1	0.0298	0.0243	1.225	0.2210
Income	1	-0.0358	0.0379	-0.946	0.3447
Race	1	0.1671	0.0605	2.761	0.0060*

Age function

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	0.0009	0.1026	-0.009	0.9928
Age	1	0.0216	0.0808	0.267	0.7895
Marital Status	1	0.0400	0.0694	-0.576	0.5648
Highest Education	1	0.0101	0.0514	-0.197	0.8442
Religion	1	0.0792	0.0361	-2.191	0.0289
Income	1	0.0172	0.0562	0.307	0.7590
Race	1	-0.0712	0.0898	-0.793	0.4280

*p > .05.

Organic causes

Variable	df	Parameter Estimate	Standard Error	T for HO: Parameter = 0	Probability > |T|
Sex	1	-0.4022	0.3009	-3.837	0.0001
Age	1	0.2854	0.1048	3.454	0.0006
Marital Status	1	-0.0315	0.0826	-0.444	0.6571
Highest Education	1	-0.0268	0.0709	-0.511	0.6093
Religion	1	0.0850	0.0525	2.301	0.0218
Income	1	-0.0754	0.0574	-1.313	0.1898
Race	1	0.1941	0.0918	2.115	0.0349*

*p > .05.

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BIOGRAPHICAL SKETCH

Lena E. Hall was born in Kingston, Jamaica, and migrated to Toronto, Canada, in 1969. She attended York University, Ontario, Canada, in 1971 and received a BA (Hon.) degree in psychology in 1975. She moved to the United States in 1976 and attended Teachers College at Columbia University, New York, between 1977 and 1979. She received the MA degree in psychology and the M.Ed. in psychological counseling and rehabilitation.

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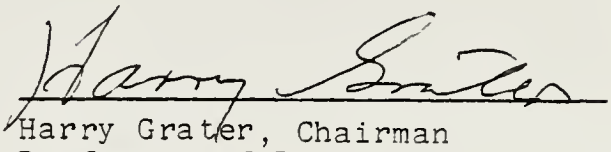

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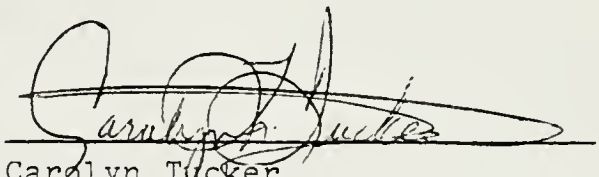

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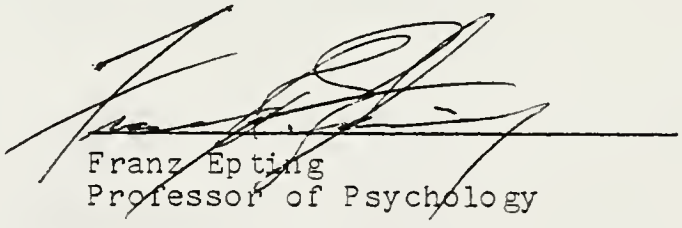

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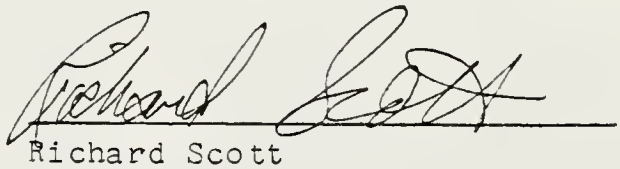

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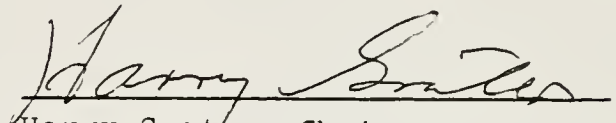

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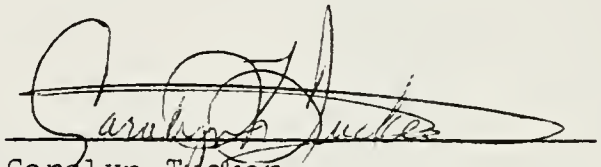

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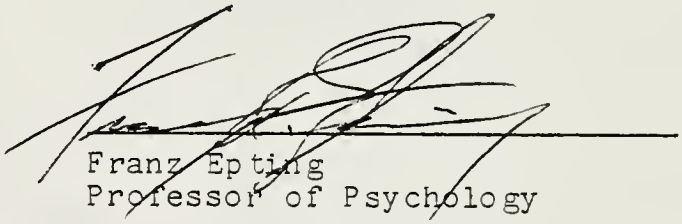

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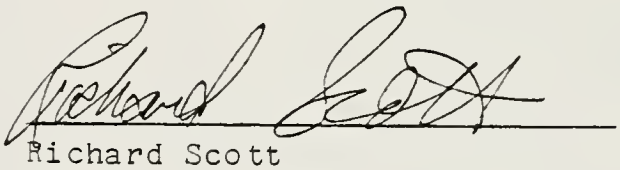

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